KENTUCKY TITLE XIX ACCOUNT

HP ENTERPRISE SERVICES

Encounter Training Workbook

TRAINING DEPARTMENT

Training Workbook- Encounter Training

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Table of Contents

INTRODUCTION

This training workbook is designed to cover the information necessary to perform basic inquiry tasks in the Claims Subsystem and the FTS System.

Workbook Audience

This manual is designed to serve the needs of the following staff:
Functional Area Users

HIPAA

HIPAA is the federal Health Insurance Portability and Accountability Act of 1996. The primary goal of the law is to make it easier for people to keep health insurance, protect the confidentiality and security of healthcare information and help the healthcare industry control administrative costs.
HIPAA protects an individual's health information and his/her demographic information. This is called "protected health information" or "PHI". Information meets the definition of PHI if, even without the patient's name, if you look at certain information and you can tell who the person is then it is PHI. The PHI can relate to past, present or future physical or mental health of the individual. PHI describes a disease, diagnosis, procedure, prognosis, or condition of the individual and can exist in any medium – files, voice mail, email, fax, or verbal communications.

In order to protect an individual's or provider's information all e-mails should be encrypted.

HIPAA defines information as protected health information if it contains the following information about the patient, the patient's household members, or the patient's employers:

- Names
- Dates relating to a patient, i.e. birthdates, dates of medical treatment, admission and discharge dates, and dates of death
- Telephone numbers, addresses (including city, county, or zip code) fax numbers and other contact information
- Social Security numbers
- Medical records numbers
- Photographs
- Finger and voice prints
- Any other unique identifying number

Workbook Structure

This workbook is divided in five **Chapters**:

- ✓ About Encounters
- ✓ Searching for Encounters
- ✓ Basic Encounter Information
- ✓ Additional Encounter Information

The **Steps** necessary to complete the action will appear at the bottom of this workbook.

Warnings may appear to alert you of common mistakes; watch for these throughout the chapters.

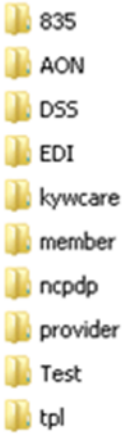
Happy Hints also appear to alert you to time-saving tips.

What is an Encounter?

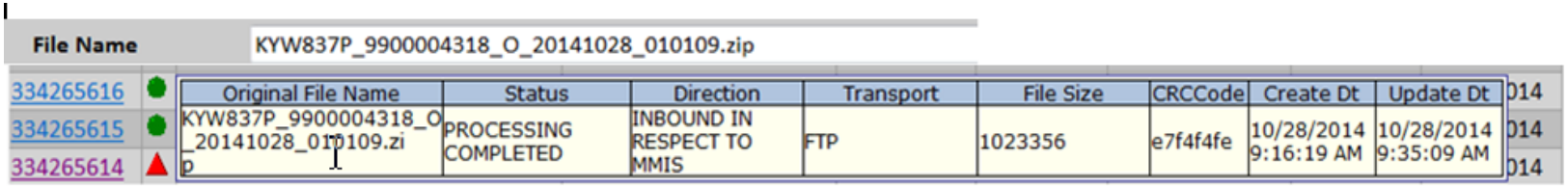
Encounters are records of a medically related service that is rendered to a Kentucky Medicaid member who is enrolled in a participating Managed Care Organization (MCO). The encounter is data from a claim that is originally processed and paid or denied by the MCO. The MMIS stores the encounter data for reporting purposes. MCOs have their own billing instructions and payment schedules that may differ from fee-for-service claims.

How are Encounter Claims submitted to MMIS?

The MCO's have access to submit files to KY Medicaid by a VPN tunnel. Each MCO has their own direct tunnel. When they connect to HP's server, they see a list of folders. Each folder is designated for a different type of file. For example: Encounter claims (837P,I,D) should be put in the EDI folder, and NCPDP files should be put in the ncpdp folder. All test files should be marked TEST_* and sent to the test folder. This folder structure and guidelines are the same for each MCO.



When an encounter file comes in, it goes through the File Transfer System (FTS).(The FTS System can only be viewed by HP EDI employees). Encounter file names should look something like this one:



File Name KYW837P_9900004318_O_20141028_010109.zip

		Original File Name	Status	Direction	Transport	File Size	CRCCode	Create Dt	Update Dt	
334265616										014
334265615		KYW837P_9900004318_O_20141028_010109.zip	PROCESSING COMPLETED	INBOUND IN RESPECT TO MMIS	FTP	1023356	e7f4f4fe	10/28/2014 9:16:19 AM	10/28/2014 9:35:09 AM	014
334265614										014

FIGURE 1 Batch File

The file then goes through the system, checking for duplicates, counts, errors, and other threshold edits or audits. Once that is complete the file will go to the Unix system and then on to new day claims.

If a file is complete and all Encounters in the file are good, a green circle appears beside the file name in FTS. If a file fails, a red triangle appears.

When a file fails, an HP EDI employee can open the file and look in the events and exceptions to see the reason.

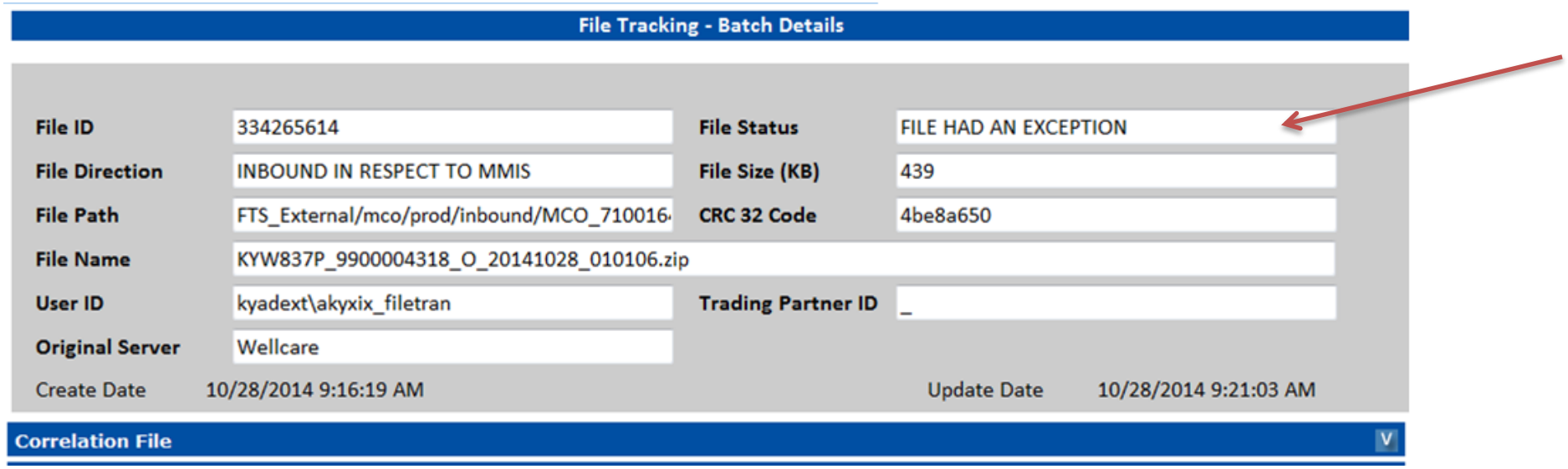


FIGURE 2 File Exception

Events

Event	Event Comments	Create Dt
RECEIVED	10.40.13.30 : FTS_External/mco/prod/inbound/MCO_7100164990/EDI	10/28/2014 9:17:03 AM
NOT_DUPLICATE		10/28/2014 9:17:03 AM
ARCHIVED	\\10.40.13.12\fts_prod\FTS_ARCHIVE\MCO_7100164990\Claim837D\2014\10\28\KYW837P_	10/28/2014 9:17:03 AM
RENAMED	334265614_4be8a650_FTP_KYW837P_9900004318_O_20141028_010106.zip	10/28/2014 9:17:03 AM
TRANSFERRED	\\10.40.13.12\fts_prod\fts\MCO_7100164990\X12\Inbound	10/28/2014 9:17:03 AM
RECEIVED_PREPROCESSOR	\\10.40.13.12\FTS_PROD\FTS\MCO_7100164990\X12\Inbound	10/28/2014 9:21:47 AM
DECOMPRESSED		10/28/2014 9:21:47 AM
RENAMED	334265614_TA15010X12BATCH_0_1of1_KYW837P_9900004318_O_20141028_010106.txt	10/28/2014 9:21:47 AM
PASSED_TO_FAILEDFOLDER	\\10.40.13.12\FTS_PROD\FTS\FAILED\	10/28/2014 9:21:47 AM
CORRELATED_FUNCTIONAL_ACK	Response File ID - 334266590	10/28/2014 9:21:51 AM
STATUS	TA1 Response: R:001	10/28/2014 9:21:51 AM
RENAMED_ACK	334266590_334265614_TA15010X12BATCH_KYW837P_9900004318_O_20141028_010106.T	10/28/2014 9:21:51 AM

Exceptions

Assembly	Method	Exception Dt	Message	Class	Server
...PreProcessors.ProcessorHandler	InitProcessing	10/28/2014 9:21:47 AM	Error in InitProcessing of Inbound base class for ...	ProcessorHandlerI...	USOLWKYVM505
...PreProcessors.ProcessorHandler	FormatCRLFTilde	10/28/2014 9:21:47 AM	File failed for TA1 validation.	ProcessorHandlerI...	USOLWKYVM505
...PreProcessors.ProcessorHandler	FormatCRLFTilde	10/28/2014 9:21:47 AM	Error in file format.	ProcessorHandlerI...	USOLWKYVM505

Notifications

FIGURE 3 File Status

This file failed because the interchange control number in the header and footer does not match (TA response shows R;001. R means rejection, see the TA1 code list in Appendix B).

If the file is accepted it goes on to new day claims. Here is an example of a good batch file from an MCO. There are no exceptions so there are no red triangles.

File ID		Original File Name	Status	Direction	Transport	File Size	CRCCode	Create Dt	Update Dt
336416628		KYW837P_9900004318_O_20141101_220209.zip	PROCESSING COMPLETED	INBOUND IN RESPECT TO MMIS	FTP	634379	46c795e7	11/4/2014 12:16:57 PM	11/4/2014 1:33:19 PM
336416627									
336416626									

FIGURE 4 A Good Batch File

Events

	Event	Event Comments	Create Dt
	RECEIVED	10.40.13.30 : FTS_External/mco/prod/inbound/MCO_7100164990/EDI	11/4/2014 12:17:55 PM
	NOT_DUPLICATE		11/4/2014 12:17:55 PM
	ARCHIVED	\\10.40.13.12\fts_prod\FTS_ARCHIVE\MCO_7100164990\Claim837D\2014\11\4\KYW837P_	11/4/2014 12:17:55 PM
	RENAMED	336416628_46c795e7_FTP_KYW837P_9900004318_O_20141101_220209.zip	11/4/2014 12:17:55 PM
	TRANSFERRED	\\10.40.13.12\fts_prod\fts\MCO_7100164990\X12\Inbound	11/4/2014 12:17:55 PM
	DECOMPRESSED		11/4/2014 1:28:08 PM
	RECEIVED_PREPROCESSOR	\\10.40.13.12\FTS_PROD\FTS\MCO_7100164990\X12\Inbound	11/4/2014 1:28:08 PM
+	BALANCING_COUNT	2744	11/4/2014 1:28:11 PM
	RENAMED	336416628_837PE5010X12BATCH_779160799_1of1_KYW837P_9900004318_O_20141101_2	11/4/2014 1:28:11 PM
+	KPI	670895.43	11/4/2014 1:28:55 PM
	CORRELATED_FUNCTIONAL_ACK	Response File ID - 336455324	11/4/2014 1:28:56 PM
	RENAMED_ACK	336455324_336416628_837PE5010X12BATCH_KYW837P_9900004318_O_20141101_22020	11/4/2014 1:28:56 PM
	PASSED_TO_BIZTALK	\\10.40.13.179\FTS\Generic_5010\Claim837P\Inbound837P\XData	11/4/2014 1:30:42 PM
	RECEIVED_POSTPROCESSOR	\\10.40.13.179\FTS\Generic_5010\Claim837P\Inbound837P\InterChange	11/4/2014 1:31:45 PM
	TRANSFERRED	\\10.40.13.12\FTS_PROD\FTS\Generic\Claim837P\Inbound837P\Postprocessor	11/4/2014 1:32:55 PM
	RECEIVED	\\10.40.13.12\fts_prod\fts\Generic\Claim837P\Inbound837P\Postprocessor	11/4/2014 1:34:16 PM
	ARCHIVED	\\10.40.13.12\fts_prod\FTS_ARCHIVE\Generic\Claim837P\2014\11\4\336416628_837PE501	11/4/2014 1:34:16
	TRANSFERRED	10.40.13.230 : /inbound/electronic	11/4/2014 1:34:17 PM
	TRANSFERRED_TO_CLAIMS	/cust/prod/dsky/data/encounters/9900004318-newday	11/4/2014 1:38:07 PM

And, there are no exceptions:

Exceptions

FIGURE 5 A Good Batch File Showing No Events

These files will go on to New Day Claims and the encounters in the file are assigned Internal Control Numbers, (ICN's) by the system. Some files are only partially accepted. This means the file itself was fine but some of the

encounters hit threshold errors. Threshold errors are errors on the encounter itself. For example on one of the encounters we are going to look at Line 4 hit the threshold error 4007-NDC Obsolete. (See Threshold Errors, Appendix A)

In This Chapter

- ✓ Logging on to the Medicaid Enterprise User Provisioning System (MEUPS)
- ✓ Accessing the interChange MMIS via MEUPS

NOTE: About System Access
A user with access to the Claims subsystem can perform Claim queries in interChange. If you do not have, but require access please contact your Manager.

Logging On to the Medicaid Enterprise User Provisioning System (MEUPS)

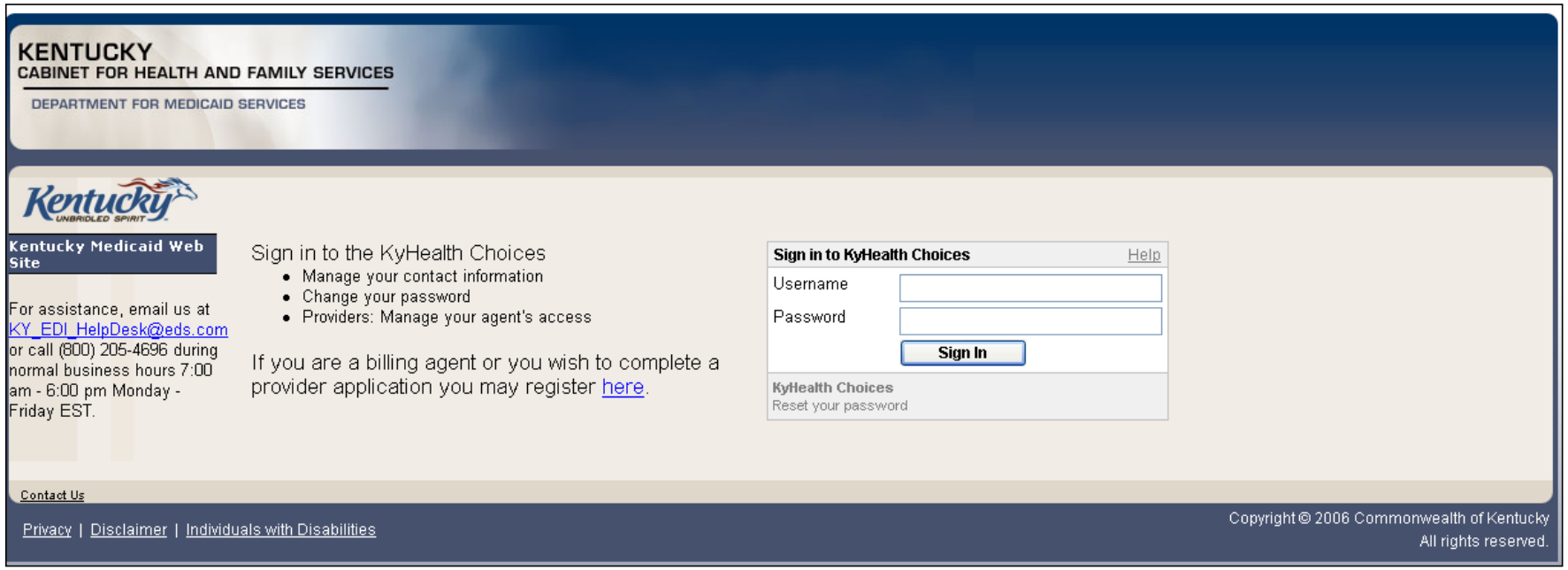


FIGURE 6 MEUPS Menu Page

FOLLOW THE STEPS.

- **Access MEUPS via the shortcut on your desktop or at https://home.kymmis.com/**

The MEUPS log on page will appear.

- **Enter your Username and Password.**
- **Click "Sign In."**

Accessing interChange from MEUPS

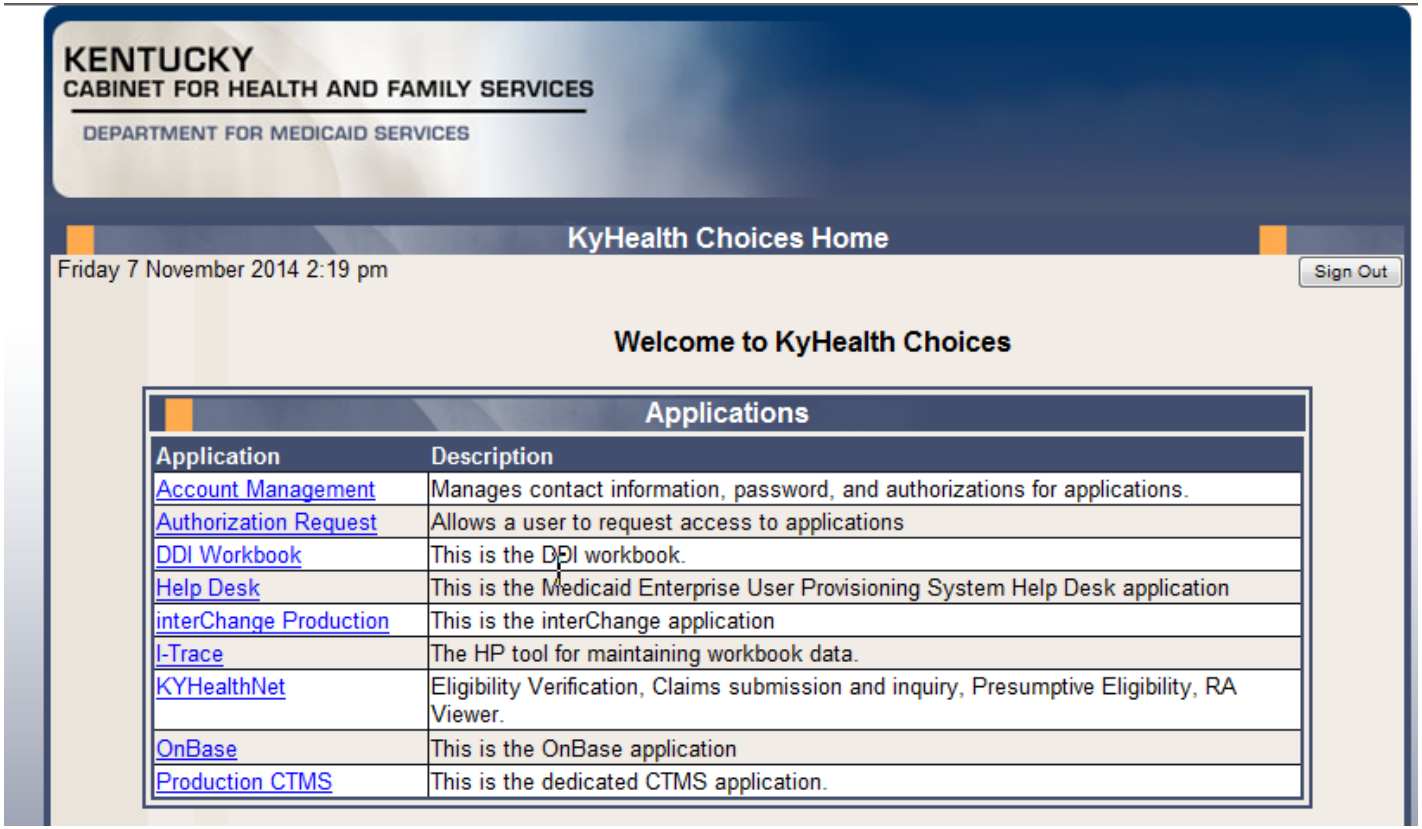


FIGURE 7 MEUPS Menu Page

FOLLOW THE STEPS

- **Select the interchange production link from the MEUPS menu.**

The interChange Home Page will appear.

Accessing the Claims Subsystem

FIGURE 8 interChange Home Page

FOLLOW THE STEPS

- **Click the "Claims" link on the main menu.**

  The Claims Search Panel will appear.

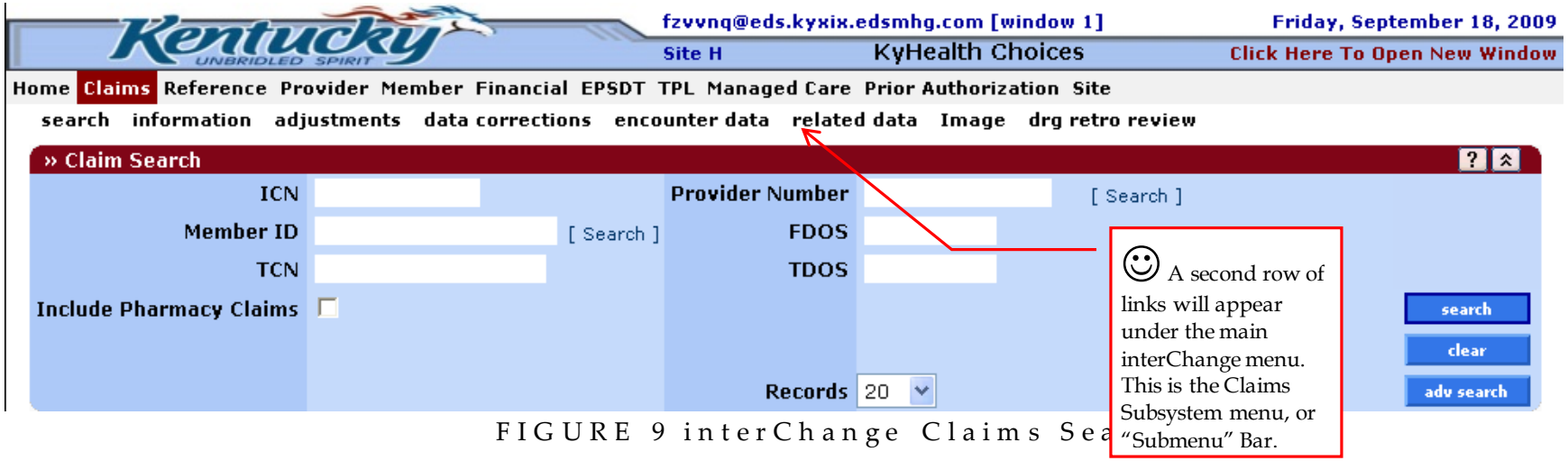


FIGURE 9 interChange Claims Sea

Each of the links which appear on the Claims Subsystem menu allow the user to perform a different type of search within the Claims subsystem.

Chapter 3: Searching for Encounter Claims

In This Chapter

- ✓ Internal Control Number (ICN)
- ✓ Encounter Regions
- ✓ Searching for Encounters
- ✓ Viewing Threshold Errors
- ✓ Searching for the NDC
- ✓ Viewing the NDC

Internal Control Number (ICN)

An Internal Control Number (ICN) is assigned by HP to each Encounter. This will be different from the MCO ICN. During the claims process: a unique control number is assigned to each individual Encounter for identification, efficient retrieval, and tracking. The ICN consists of 13 digits and contains the following information:

75—14—032—123—456

1 2 3 4 5

1. Encounter Region (see list below)
2. Year of Receipt
3. Julian Date of Receipt

The Julian calendar numbers the days of the year 1-365. For instance, 001 is January 1st, and 032 (shown above) is February 1st.

4. Batch Number
5. Encounter Number

ENCOUNTER REGIONS

Region Code	Description
70	ENCOUNTER
71	ENCOUNTER PHARMACY
72	CONVERTED ENCOUNTER PHARMACY
73	CONVERTED ENCOUNTER
75	MCO ENCOUNTER - NEW DAY ENCOUNTER
76	MCO ENCOUNTER - ADJUSTMENT
77	MCO ENCOUNTER - VOIDS
78	MCO ENCOUNTER - PHARMACY NEW DAY ENCOUNTER
79	MCO ENCOUNTER - PHARMACY VOIDS
85	SUPPLEMENTAL PAYMENT CLAIMS
86	SUPPLEMENTAL PAYMENT CLAIM ADJUSTMENT
87	SUPPLEMENTAL PAYMENT CLAIM VOID
88	SUPPLEMENTAL PAYMENT CLAIM MASS ADJUSTMENT

Julian Date Calendar (NON- leap year)

DAY	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	DAY
1	001	032	060	091	121	152	182	213	244	274	305	335	1
2	002	033	061	092	122	153	183	214	245	275	306	336	2
3	003	034	062	093	123	154	184	215	246	276	307	337	3
4	004	035	063	094	124	155	185	216	247	277	308	338	4
5	005	036	064	095	125	156	186	217	248	278	309	339	5
6	006	037	065	096	126	157	187	218	249	279	310	340	6
7	007	038	066	097	127	158	188	219	250	280	311	341	7
8	008	039	067	098	128	159	189	220	251	281	312	342	8
9	009	040	068	099	129	160	190	221	252	282	313	343	9
10	010	041	069	100	130	161	191	222	253	283	314	344	10
11	011	042	070	101	131	162	192	223	254	284	315	345	11
12	012	043	071	102	132	163	193	224	255	285	316	346	12
13	013	044	072	103	133	164	194	225	256	286	317	347	13
14	014	045	073	104	134	165	195	226	257	287	318	348	14
15	015	046	074	105	135	166	196	227	258	288	319	349	15
16	016	047	075	106	136	167	197	228	259	289	320	350	16
17	017	048	076	107	137	168	198	229	260	290	321	351	17
18	018	049	077	108	138	169	199	230	261	291	322	352	18
19	019	050	078	109	139	170	200	231	262	292	323	353	19
20	020	051	079	110	140	171	201	232	263	293	324	354	20
21	021	052	080	111	141	172	202	233	264	294	325	355	21
22	022	053	081	112	142	173	203	234	265	295	326	356	22
23	023	054	082	113	143	174	204	235	266	296	327	357	23
24	024	055	083	114	144	175	205	236	267	297	328	358	24
25	025	056	084	115	145	176	206	237	268	298	329	359	25
26	026	057	085	116	146	177	207	238	269	299	330	360	26
27	027	058	086	117	147	178	208	239	270	300	331	361	27
28	028	059	087	118	148	179	209	240	271	301	332	362	28
29	029		088	119	149	180	210	241	272	302	333	363	29
30	030		089	120	150	181	211	242	273	303	334	364	30
31	031		090		151		212	243		304		365	31
DAY	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	DAY

Julian Date Calendar (leap year)

DAY	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	DAY
1	001	032	061	092	122	153	183	214	245	275	306	336	1
2	002	033	062	093	123	154	184	215	246	276	307	337	2
3	003	034	063	094	124	155	185	216	247	277	308	338	3
4	004	035	064	095	125	156	186	217	248	278	309	339	4
5	005	036	065	096	126	157	187	218	249	279	310	340	5
6	006	037	066	097	127	158	188	219	250	280	311	341	6
7	007	038	067	098	128	159	189	220	251	281	312	342	7
8	008	039	068	099	129	160	190	221	252	282	313	343	8
9	009	040	069	100	130	161	191	222	253	283	314	344	9
10	010	041	070	101	131	162	192	223	254	284	315	345	10
11	011	042	071	102	132	163	193	224	255	285	316	346	11
12	012	043	072	103	133	164	194	225	256	286	317	347	12
13	013	044	073	104	134	165	195	226	257	287	318	348	13
14	014	045	074	105	135	166	196	227	258	288	319	349	14
15	015	046	075	106	136	167	197	228	259	289	320	350	15
16	016	047	076	107	137	168	198	229	260	290	321	351	16
17	017	048	077	108	138	169	199	230	261	291	322	352	17
18	018	049	078	109	139	170	200	231	262	292	323	353	18
19	019	050	079	110	140	171	201	232	263	293	324	354	19
20	020	051	080	111	141	172	202	233	264	294	325	355	20
21	021	052	081	112	142	173	203	234	265	295	326	356	21
22	022	053	082	113	143	174	204	235	266	296	327	357	22
23	023	054	083	114	144	175	205	236	267	297	328	358	23
24	024	055	084	115	145	176	206	237	268	298	329	359	24
25	025	056	085	116	146	177	207	238	269	299	330	360	25
26	026	057	086	117	147	178	208	239	270	300	331	361	26
27	027	058	087	118	148	179	209	240	271	301	332	362	27
28	028	059	088	119	149	180	210	241	272	302	333	363	28
29	029	060	089	120	150	181	211	242	273	303	334	364	29
30	030		090	121	151	182	212	243	274	304	335	365	30
31	031		091		152		213	244		305		366	31
DAY	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	DAY

Use the ICN, or the Member ID, Provider ID and date of service to search for an Encounter. When using an ICN to search, only one result will be returned. The Encounter Information Page will automatically be displayed.

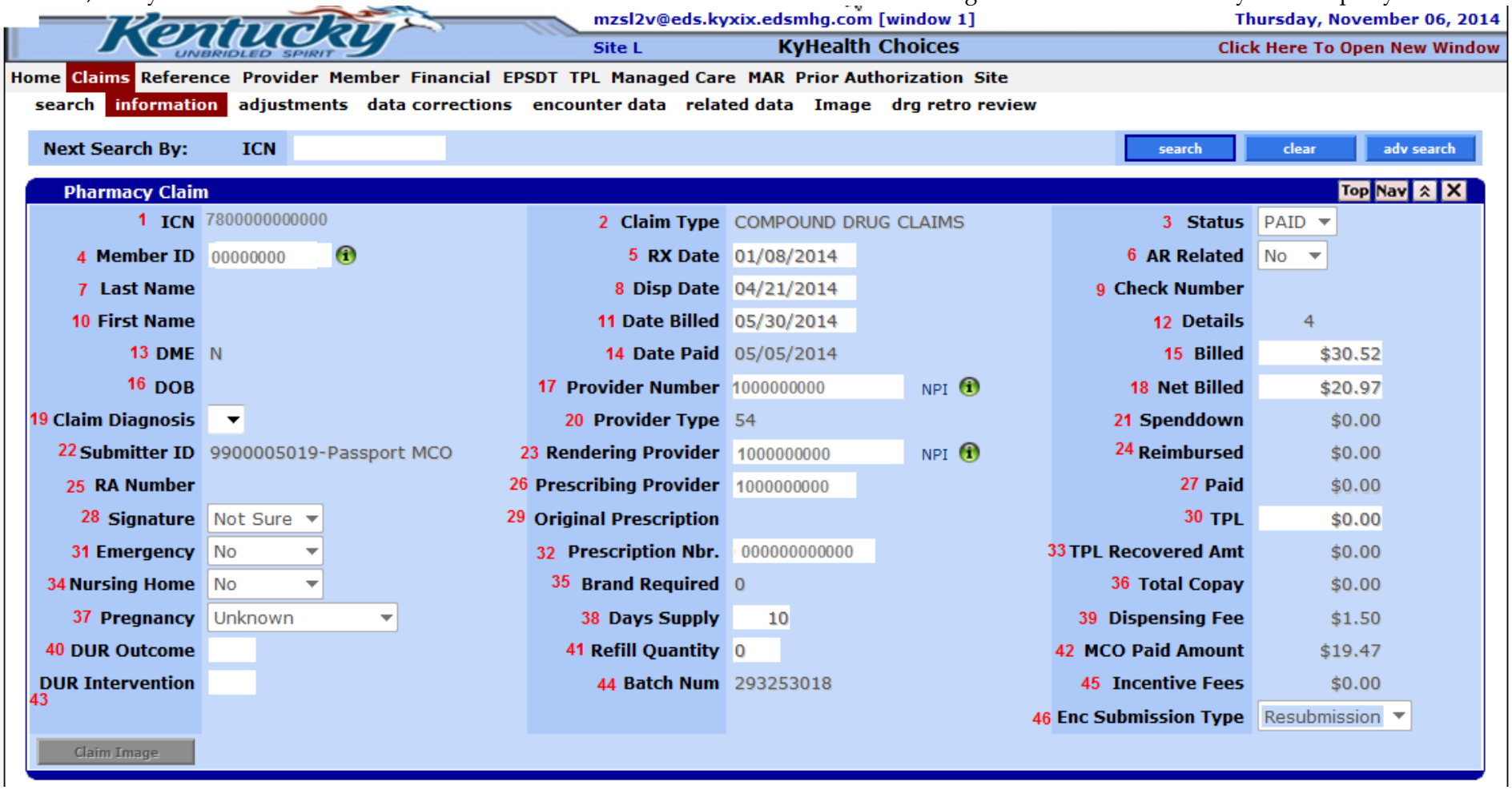


FIGURE 10 Pharmacy Encounter Information Panel

Field Descriptions

Field No.	Field	Description
1	ICN	Internal Control Number which uniquely identifies an Encounter
2	Encounter Type	Indicates the type of Encounter.
3	Status	Identifies the status of the Encounter in the system.
4	Member ID	A system-assigned number which uniquely identifies a member.
5	RX Date	Date the drug prescription (Rx) was either filled or written.
6	AR Related	Indicates any AR's associated with the Encounter.
7	Last Name	The last name of the member associated with the Member ID number.
8	Dispensed Date	Date pharmacy dispensed the drug to the member.
9	Check Number	This field is not used
10	First Name	The first name of the member associated with the Member ID number.
11	Date Billed	The date on which an Encounter was submitted for processing.
12	Details	The number of detail service lines on the Encounter.
13	DME	Indicates whether the Encounter was for Durable Medical Equipment.
14	Date Paid	The date the Encounter processed.
15	Billed Amount	Amount of money requested for payment by a provider for services rendered. Format 999999.99
16	Date of Birth	Member's date of birth.
17	Provider Number	The provider identification number and location that uniquely identifies the provider of services.
18	Net Billed	Amount remaining on an Encounter after payment has been made by all other sources (co-pay, TPL, and so on.). Format 999999.99
19	Claim Diagnosis	Indicates the diagnosis codes applicable to the Encounter
20	Provider Type	Indicates the type of provider that is billing the Encounter.
21	Spenddown	Amount of money that member is responsible for paying for services rendered. Format 9999999.99
22	Submitter ID	15 character identification code published by the sender for other parties to use as the receiver ID to route data to them.
23	Rendering Provider	ID and service location of the provider rendering the service.
24	Reimbursed	Total amount the provider receives minus any State Share Amount (if applicable). Format 99999999.99
25	RA Number	This field is not used
26	Prescribing Provider	NPI of provider who prescribed the drugs to the member.
27	Paid	Amount paid on the Encounter.
28	Signature	Indicates whether the Encounter was signed by the provider or representative.
29	Original Prescription	Original prescription number.
30	TPL	Amount paid by third party for services. Format 999999.99

Field No.	Field	Description
31	Emergency	Indicates whether this is an emergency supply.
32	Prescription Number	Number assigned by a pharmacy to identify the drug dispensed to a member.
33	TPL Recovered Amount	The casualty case recovery amount populated from the Settlement window. Format 9999999.99
34	Nursing Home	Indicates whether the member is in a nursing home.
35	Brand Required	Indicates the reason, if any, that a brand name drug was dispensed.
36	Total Copay	Amount paid by member for services rendered.
37	Pregnancy	Pregnancy Indicator.
38	Day's Supply	Number of days a prescribed drug should last a member.
39	Dispensing Fee	Amount of dispensing fee, if paid. Format 99999.99
40	DUR Outcome	The response of the pharmacist to the DUR message.
41	Refill Quantity	Number of refills on the prescription billed.
42	MCO Paid Amount	The amount paid by the MCO.
43	DUR Intervention	The response of the pharmacist to the DUR message.
44	Batch Number	The unique number of the batch the Encounter came from
45	Incentive Fees	Indicates any incentive fees paid to the provider by the MCO.
46	Encounter Submission Type	Indicates the type of Encounter that was submitted

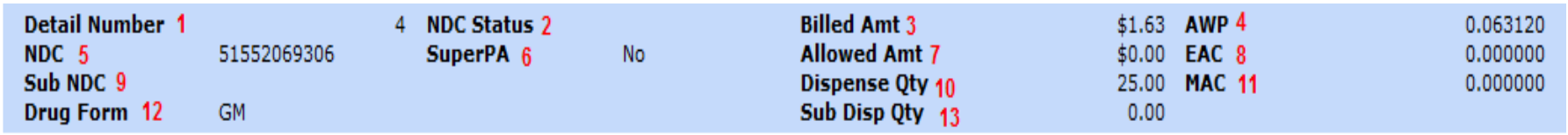


FIGURE 11 Pharmacy Encounter Detail

Field Descriptions

Field No.	Field	Description
1	Detail Number	The number of the detail on an Encounter record.
2	NDC Status	Identifies the status of the National Drug Code in the system.
3	Billed Amount	Amount of money requested for payment by a provider for services rendered. Format 999999.99.
4	AWP Rate	The Average Wholesale Price.
5	NDC	Unique code assigned to a drug product by the FDA and the manufacturer or distributor. It identifies the manufacturer/distributor, drug, dosage form, strength, and package size.
6	Super PA	Indicates there is Super PA data for PA. (NOTE: This is not used in KY)
7	Allowed Amount	The MCO allowed amount. (NOTE: This field is not used)
8	EAC	The Estimated Acquisition Cost of the drug for the pharmacy.
9	Sub NDC	Submitted NDC for HIPAA 835' (no longer used)
10	Dispense Quantity	Indicates the amount that was dispensed.
11	MAC	The Federal Maximum Allowable Cost.
12	Drug Form	Indicates the type of billing unit to be used for a product. E.G. Each (tablets, kits, etc.)
13	Sub dispense Quantity	Submitted Dispense Quantity for HIPAA 835' (No longer used)

LESSON 3 Viewing Threshold errors

Clicking on the error link in the navigation panel will show any thresholds the Encounter hit.

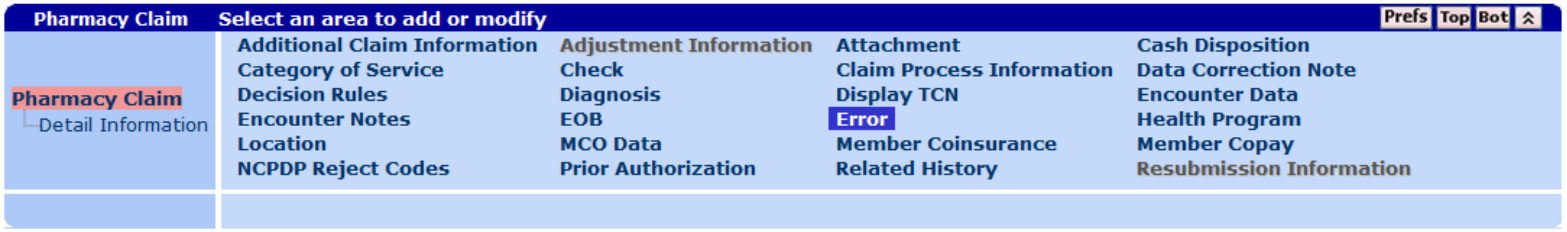


FIGURE 12 Error Link

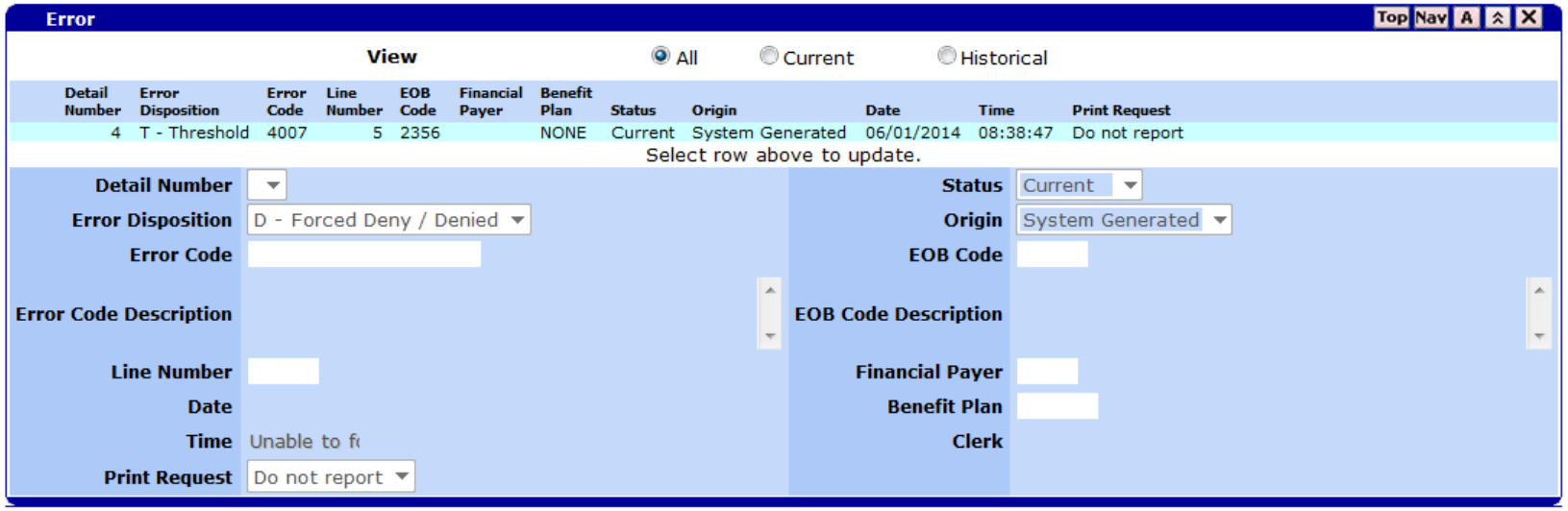


FIGURE 13 Pharmacy Threshold Detail

FOLLOW THE STEPS

- **Click on the error link in the navigation panel**
- **Click on the Line to see the error code description**

When you click on the line the panel will open up and give you a description of the threshold edits. (See Appendix A)

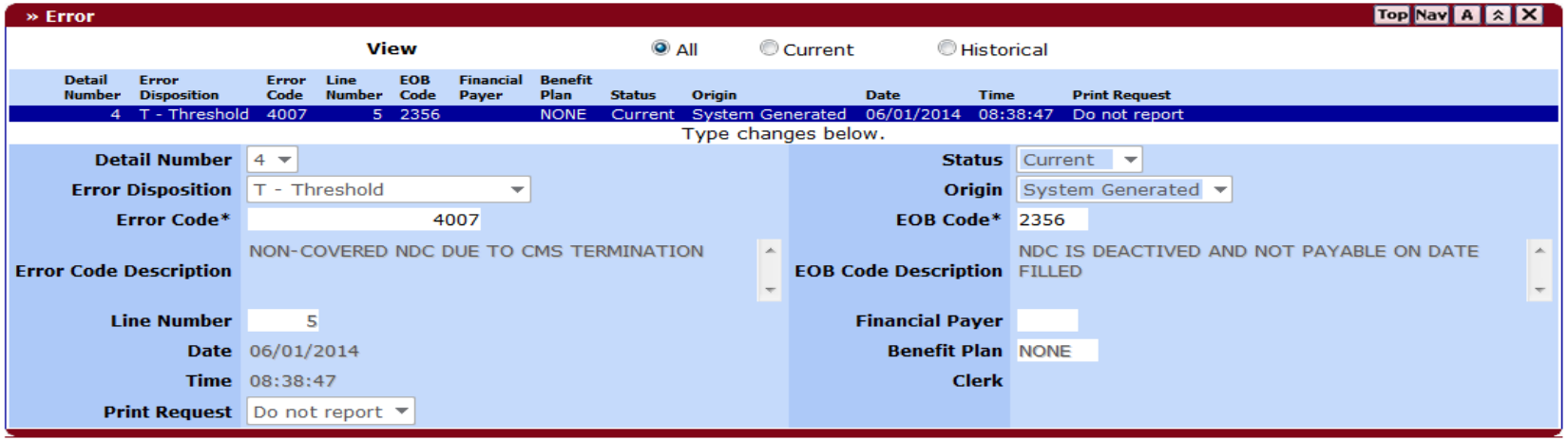


FIGURE 14 Pharmacy Threshold Detail Description

Since detail line 4 on this Encounter detail hit the Threshold Edit for a non-covered NDC due to termination you will need to go to the Drug subsystem under Reference.

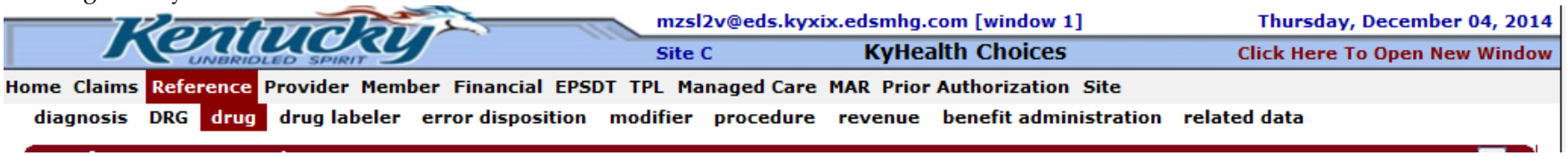


FIGURE 15 Reference And Drug Subsystems

Type in the NDC and click on search. (Enter the NDC that hit the threshold, 51552069306.)

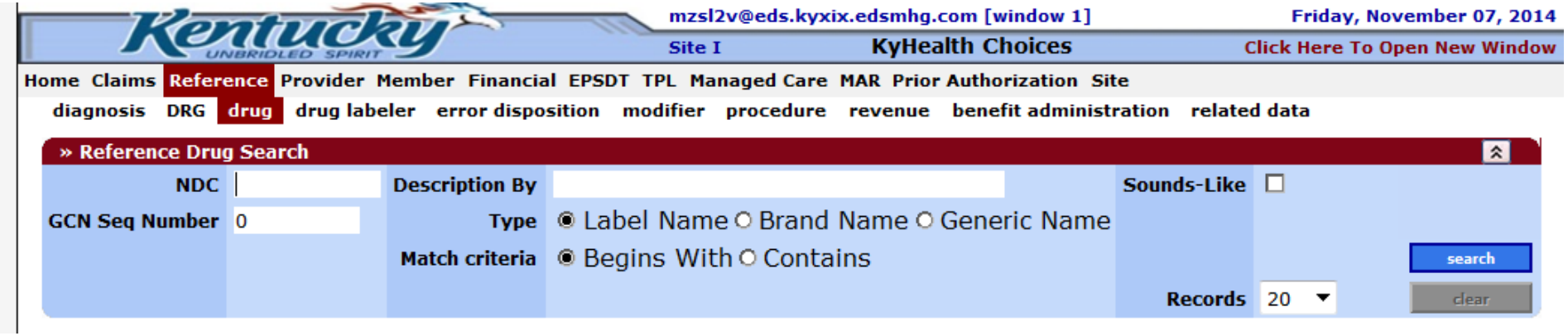


FIGURE 16 NDC Search

FOLLOW THE STEPS

- Enter the NDC (National Drug Code)

Then you need to look for the obsolete date of the NDC. In this case, the NDC became obsolete on 12/11/2012. If the DOS billed is greater than 366 days from the obsolete date, the detail will fail. The date of service on the Encounter detail is 1/8/2014-4/28/2014.

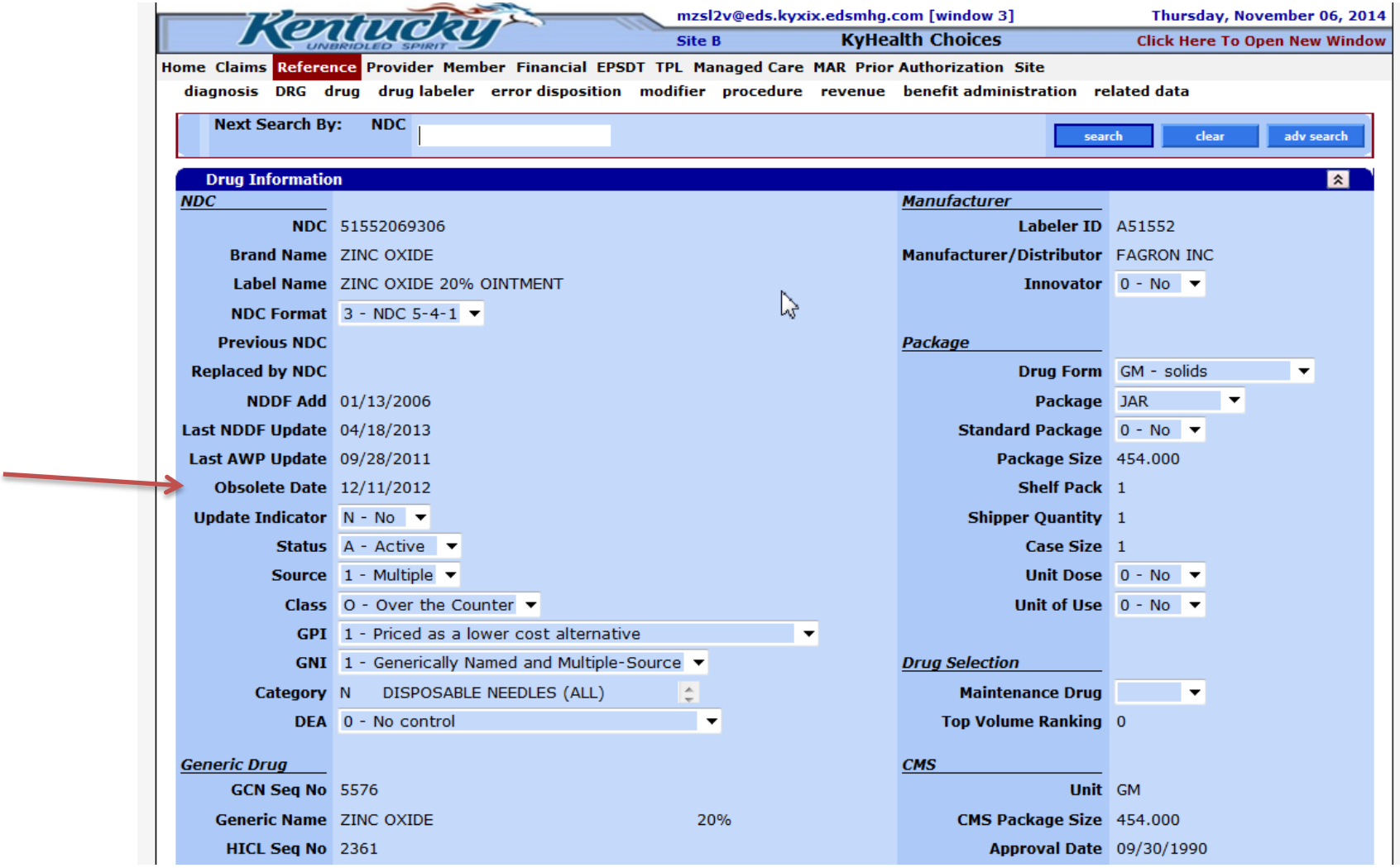


FIGURE 17 NDC Obsolete Date

Any time an Encounter hits a threshold the entire encounter is thresholded and must be resubmitted in an R type file. This file is named by the MCO.

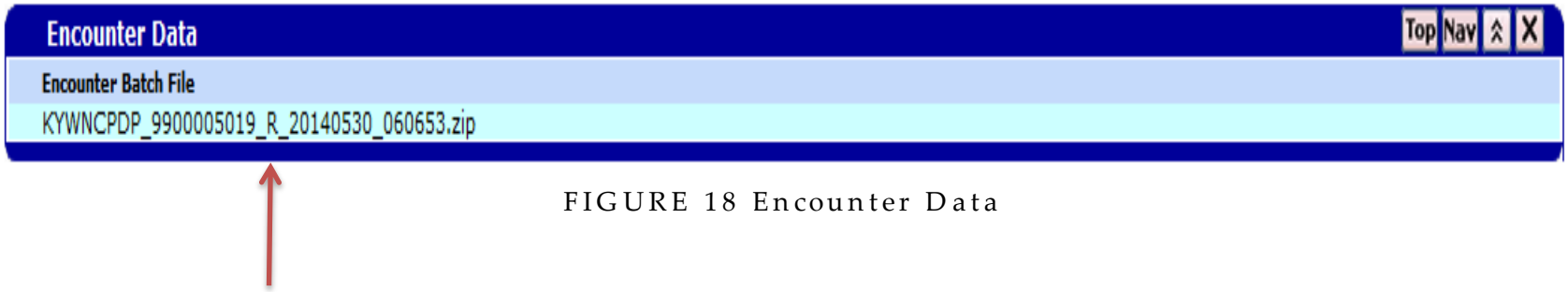


FIGURE 18 Encounter Data

There are several different types of file submissions, for example:

- **O – Original (new claims)**
- **R – Resubmission (claims that have been billed before but did not process for some reason)**
- **A – Adjustment (adjustments to existing claims)**
- **V – Void (voids for both 837 and pharmacy)**
- **D – Denied**

PANEL: CMS 1500 (Professional Claim) Information

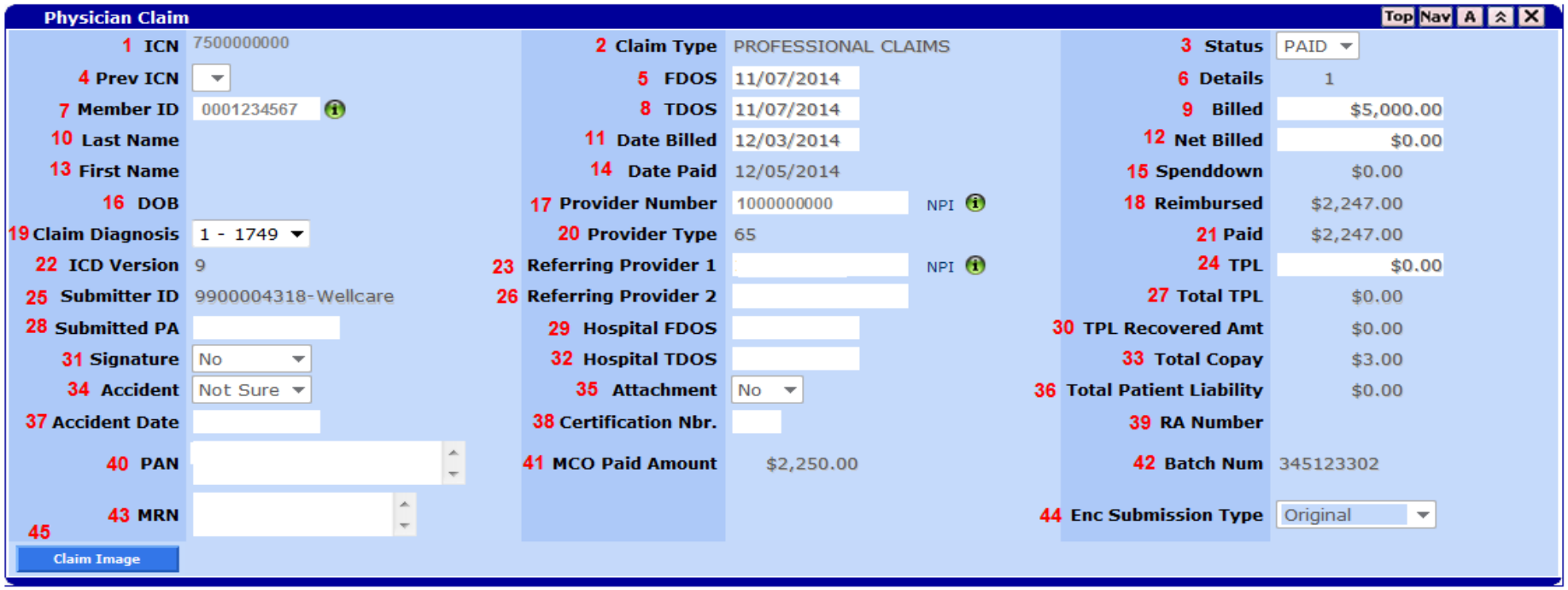


FIGURE 19 CMS 1500 Claim Information Panel

Field Descriptions

Field No.	Field	Description
1	ICN	The 13-digit Internal Control Number which uniquely identifies an Encounter. This is a system-assigned number.
2	Claim Type	Indicates the type of claim. This information is system-generated based on the claim form, the Provider type and other information on the Encounter. For example, if a UB04 claim is submitted by an acute care hospital, the Claim Type could be Inpatient Hospital, Outpatient Hospital, Inpatient Crossover or Outpatient Crossover. The Type of Bill code and Payer information would be used to determine which of the four is appropriate.
3	Status	This field displays the status of the Encounter. This is system-generated. Paid and Denied are valid Encounter statuses.
4	Prev ICN	If a denied Encounter is systematically extracted and re-processed, the original Encounter ICN will show here.
5	FDOS	Beginning date of service on the Encounter. On a CMS 1500 form, there is not a "header" field for date of service, so this field is populated based on the earliest date appearing on the Encounter details.

Field No.	Field	Description
6	Details	The number of detail service lines on the Encounter. This is systematically populated based on the count of line items.
7	Member ID	An assigned number which uniquely identifies a Member. The Member's current ID number displays here, even if an old ID was submitted on the claim form.
8	TDOS	Ending date of service on the Encounter. On a CMS 1500 form, there is not a "header" field for date of service, so this field is populated based on the latest date appearing on the Encounter details.
9	Billed	Amount requested by the provider for services rendered. Format 999999.99 This is populated from the claim form.
10	Last Name	The last name of the Member. This is populated from the claim.
11	Date Billed	Date on which Encounter was submitted for processing
12	Net Billed	Amount remaining on a Encounter after payment has been made by all other sources (co-pay, TPL, and so on.). Format 999999.99. This is populated from the Encounter information.
13	First Name	The first name of the Member. This is populated from the claim form.
14	Date Paid	Date on which the Encounter was finalized (completed a financial cycle). A date in this field indicates the Encounter has been finalized, and a date will appear here after finalization even if the Encounter is Denied.
15	Spenddown	Amount of money applied to the Member's spenddown. Format 9999999.99
16	DOB	Member date of birth. This is system-generated; not populated from the claim form.
17	Provider Number	The billing, or pay-to, Provider NPI (or Medicaid Provider number for atypical Providers).
18	Reimbursed	Total amount the provider receives. Format 9999999.99
19	Claim Diagnosis	Code used to identify the diagnosis, or medical reason for treatment. These are populated from the claim form.
20	Provider Type	Two digit code that signifies Provider type. This is system-generated based on the information on the Provider's file.
21	Paid	Amount paid on claim. Format 999999.99
22	ICD Version	The version of the ICD code.
23	Referring Provider 1	The NPI of the Referring physician other than the rendering Provider. This is populated from the claim form.
24	TPL	Amount paid by third party for services at the Encounter header level. Format 999999.99
25	Submitter ID	15 character identification code published by the sender for other parties to use as the receiver ID to route data to them.
26	Referring Provider 2	The NPI of a physician other than the rendering Provider. This is populated from the claim form.
27	Total TPL	The sum of the TPL amounts at the header and detail levels Format 999999.99
28	Submitted PA	Prior Authorization number submitted by the Provider.
29	Hospital FDOS	First date hospitalized. Kentucky Medicaid does not use this information on a CMS 1500 claim.
30	TPL Recovered Amt	In some cases, Medicaid pays a claim and recovers money from a third party. The recovered amount populated from the settlement panel. Format 9999999.99
31	Signature	Indicates whether the claim was signed by the provider or representative. A signature is not required.
32	Hospital TDOS	Last date hospitalized. Kentucky Medicaid does not use this information on a CMS 1500 claim.
33	Total Copay	The sum of all the detail co-pay amounts applicable to the Encounter. Format 99999.99. This field is only populated if the copay is deducted from the Encounter Allowed amount. If the copay is additive, it will not appear here.
34	Accident	Indicates whether the service performed was as a result of an accident. Populated from the Encounter information. If the Encounter indicates the service was the result of an accident, Medicaid may deny the Encounter or pay it and send a subrogation questionnaire to the Member.

Field No.	Field	Description
35	Attachment	Indicates whether an attachment is present. This is triggered by the claim region code. Claims with regions 11 and 90 will have an attachment indicator of "yes." This is not used for Encounters.
36	Total Patient Liability	The amount of patient liability applied to this Encounter.
37	Accident Date	Date of accident. Populated from the Encounter information.
38	Certification Nbr	Code used to identify the certification of the member. Not used in Kentucky.
39	RA Number	Remittance Advice number, uniquely identifies remittance advice sent to providers during payment cycles
40	PAN	Patient's unique identification number assigned by the provider to track the patient's financial records. This is not used in Encounter processing.
41	MCO Paid Amount	For encounters, this is the amount paid by the Managed Care Organization (such as Passport).
42	Batch Number	Code representing the number of the batch that the Encounter was in. This is not used in claims processing.
43	MRN	Code representing the Medical Record Number. This is submitted by the Provider, and is not used in claims processing.
44	Enc Submission Type	Type of encounter submission

Button Descriptions

Field No.	Field	Description
44	Claim Image	Opens new browser with scanned image of claim.

On this Encounter we are showing 2 threshold edits. The detail number says 0 so this applies to the whole Encounter. For a list of claim types each provider can bill see Appendix D.

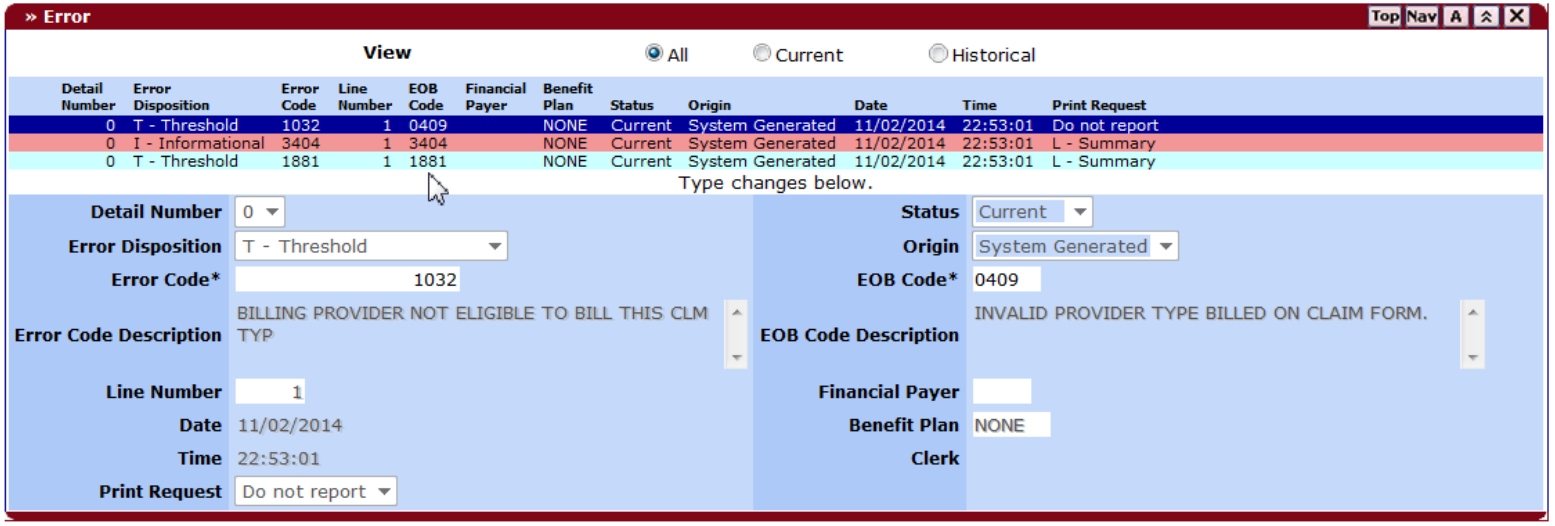


FIGURE 20 Threshold Edit 1

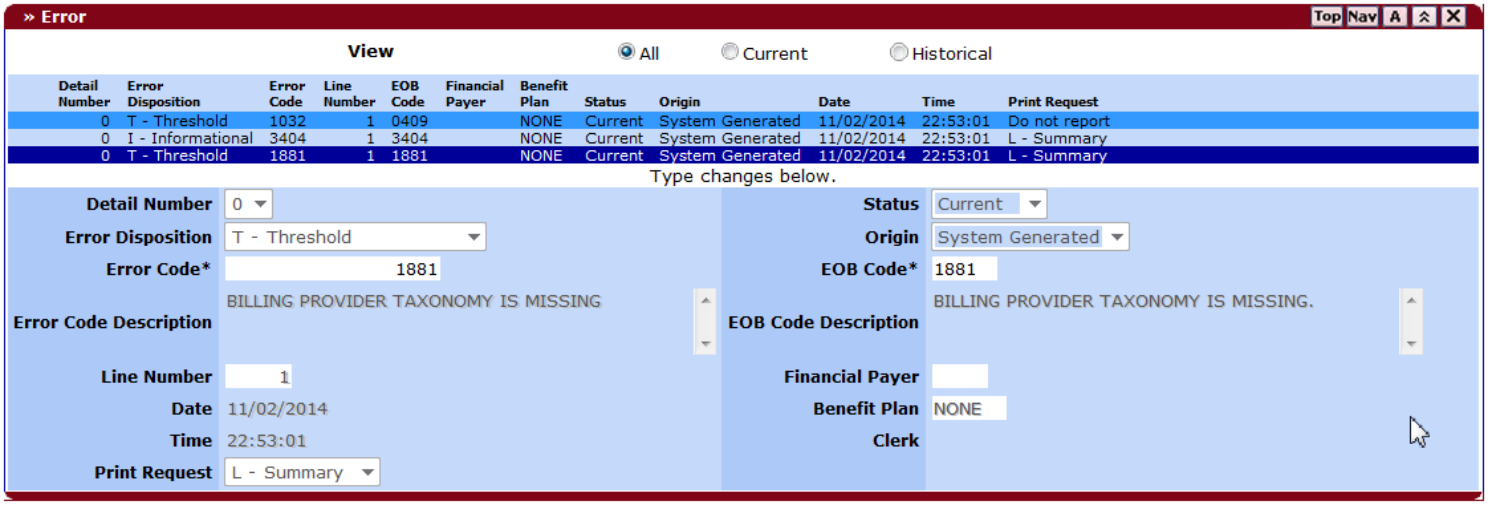


FIGURE 21 Threshold Edit 2

The Additional Claim Information link in the navigation panel will open the Additional Claim Information panel which shows the taxonomy submitted on the encounter along with the NPI and submitter ID.

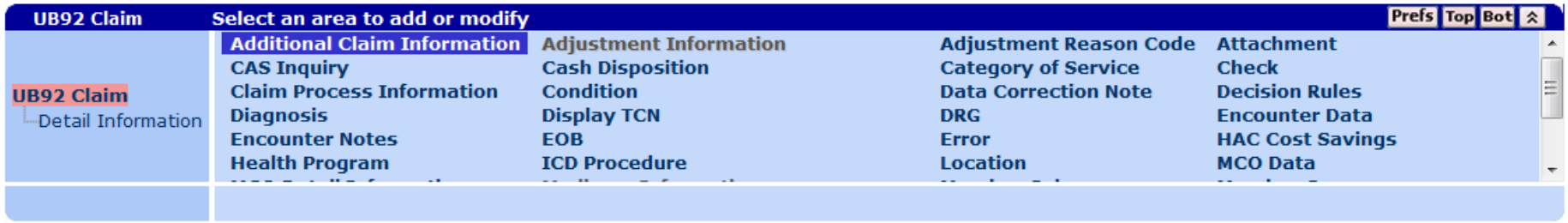


FIGURE 22 Additional Claim Information

FOLLOW THE STEPS

Click on the Additional Claim Information link in the navigation panel

FIGURE 23 Additional Claim Information Panel

Entity Type Identifiers

- **41 Submitter**
- **71 Attending Physician**
- **72 Operating Physician**
- **77 Service Location**
- **85 Billing Provider**
- **IL Insured or Subscriber**

For a complete list you can go to the Reference system, Related Data subsystem, and HealthCare Entity Identifier.

In This Chapter

- ✓ **Encounter Data**
- ✓ **Encounter Notes**
- ✓ **MCO Data**
- ✓ **MCO Detail Information**
- ✓ **Adjustment Reason Code Panel**

Clicking on the Encounter Data link in the navigation panel allows you to see the batch file ID that this encounter came in on.

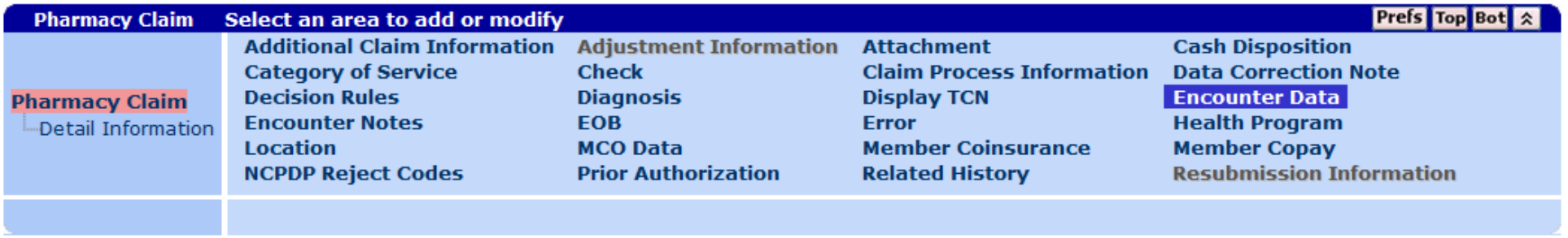


Figure 24 Encounter Data Link

FIGURE 25 Encounter Data Panel

FOLLOW THE STEPS

Click on the Encounter Data link in the navigation panel.

PANEL: Encounter Notes

Clicking on the Encounter notes link in the navigation panel will bring up the any notes attached to the Encounter.

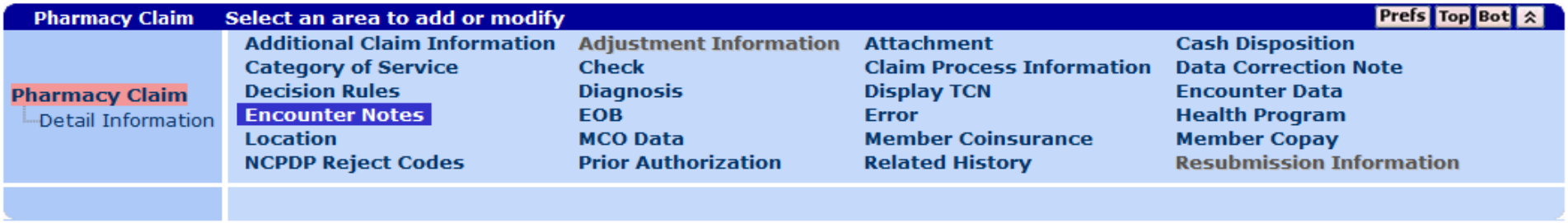


FIGURE 26 Encounter Notes Link

There are the segments in the 837 transaction where the MCOs indicate a denial has been made by the MCO. A1 is the code for denial.

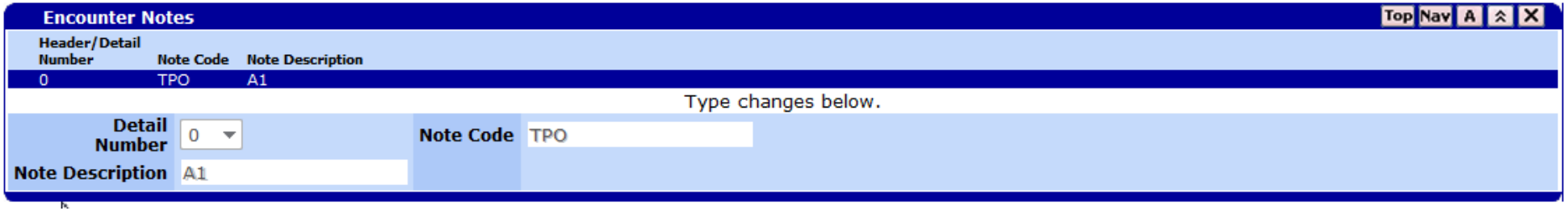


FIGURE 27 Encounter Notes Panel

FOLLOW THE STEPS

- **Click on the Encounter Notes link in the navigation panel**

PANEL: MCO Data

Clicking on the MCO Data link in the Navigation Panel opens the MCO Data panel.

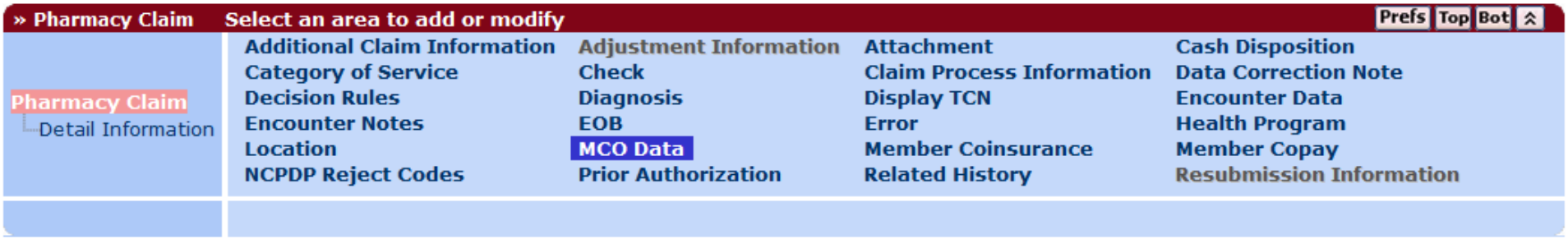


Figure 28 MCO Data Link

This panel gives information on the Encounter like the MCO ICN, the payment date and the submission type.

FIGURE 29 MCO Data Panel

FOLLOW THE STEPS

- **Click on the MCO Data link in the navigation panel**

Field Descriptions

Field No.	Field	Description
1	MCO ICN	The ICN assigned by the MCO.
2	MCO Payment Date	The date the MCO paid on the claim.
3	MCO Receipt Date	
4	Encounter Receipt Date	The date MMIS received the Encounter information.
5	Encounter Type	The type of submission of the Encounter.

Field No.	Field	Description
6	Adjudicated Status	Indicates that it is for informational purposes only.
7	MCO Paid Amount	Indicates the amount paid by the MCO..
8	MMIS allowed Amount	Indicates the allowed amount in MMIS.
9	MCO Capitation	Indicates if this is a capitation Encounter.

PANEL: MCO Detail Information

Click the MCO Detail link in the Navigation panel to bring up the MCO Detail Information.to see the paid dates of each detail line.

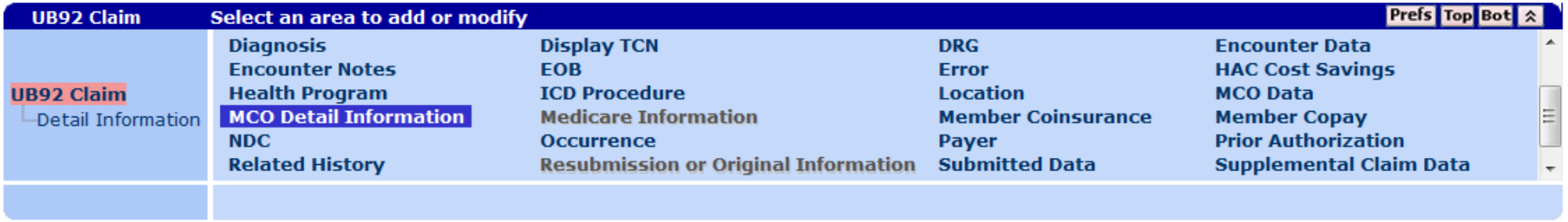


FIGURE 30 MCO Detail Information Link

The MCO Detail Information tells when each detail line was paid.

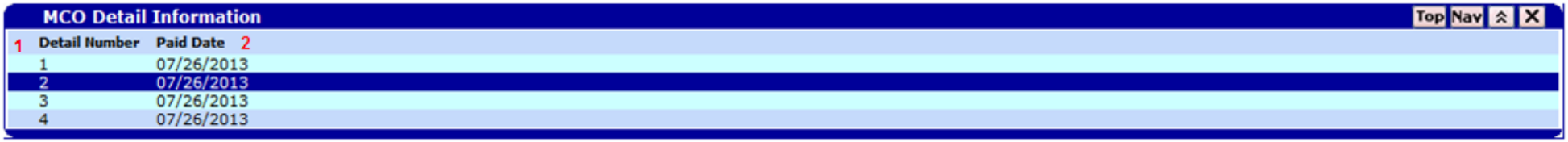


FIGURE 31 MCO Detail Information Panel

FOLLOW THE STEPS

Click on the MCO Data link in the navigation panel

Field Descriptions

Field No.	Field	Description
1	Detail Number	The detail number of the encounter
2	Paid Date	The date the detail was paid

PANEL: Adjustment Information

When an Encounter has been adjusted you can see the original information and any other adjustments done to the Encounter under the Adjustment Information link in the Navigation panel.

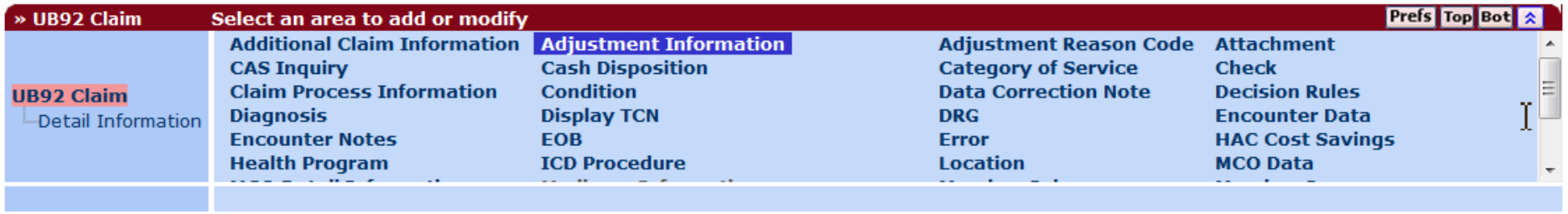
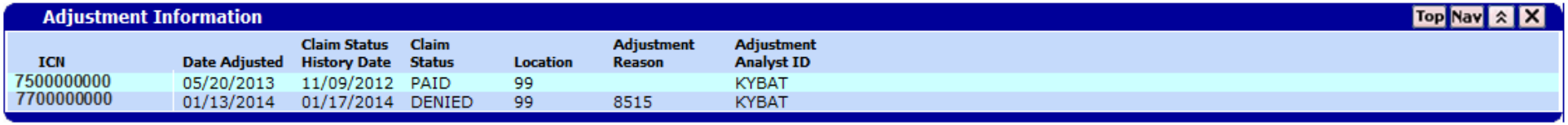


FIGURE 32 Adjustment Information Link



ICN	Date Adjusted	Claim Status History Date	Claim Status	Location	Adjustment Reason	Adjustment Analyst ID
7500000000	05/20/2013	11/09/2012	PAID	99		KYBAT
7700000000	01/13/2014	01/17/2014	DENIED	99	8515	KYBAT

FIGURE 33 Adjustment Information Panel

PANEL: Adjustment Reason Code

Sometimes an Encounter is adjusted or denied. Clicking on the Adjustment Reason Codes link in the Navigation panel will open the Adjustment Reason Code panel.

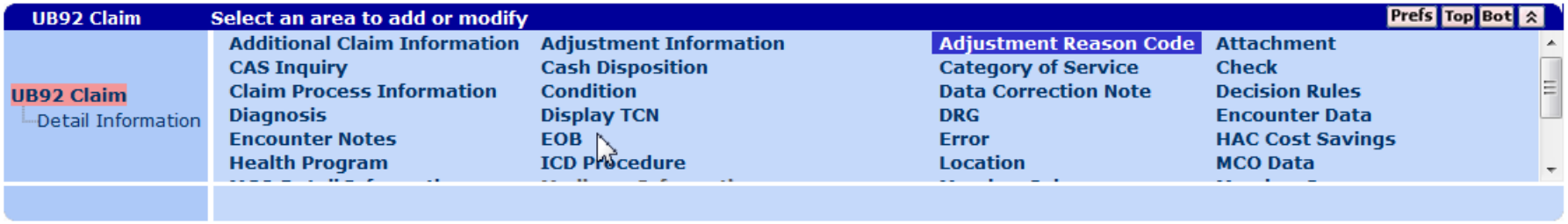


FIGURE 34 Adjustment Reason Code Link

The Panel shows the adjustment reason codes from MCO denied encounters and/or partially paid encounters with denied details. These codes come from the MCO's.(See Appendix C for Adjustment Reason Codes)

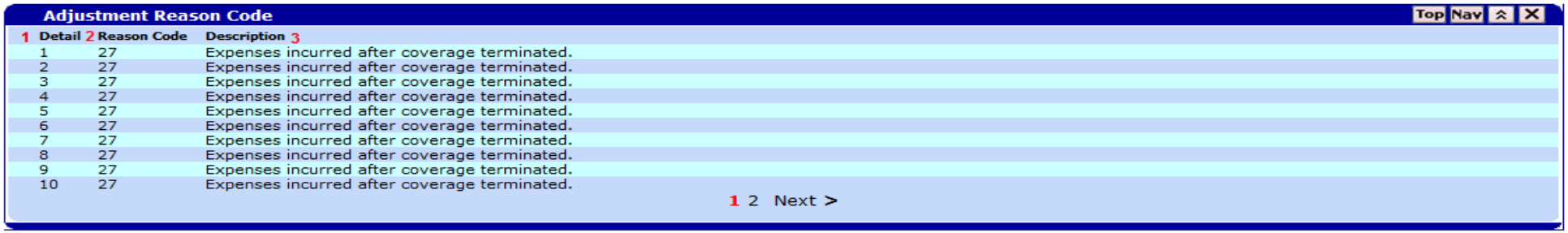


FIGURE 35 Adjustment Reason Code Panel

FOLLOW THE STEPS

Click on the Adjustment Reason Code link in the navigation panel

Field Descriptions

Field No.	Field	Description
1	Detail	Claim detail number.
2	Reason Code	Adjustment Reason Code from MCO / Passport denied encounters and /or partially paid encounters with denied details.
3	Description	Description of Adjustment Reason Code.

In This Chapter

- ✓ **EDI Encounter Batch Status**
- ✓ **Encounter Batch Summary**
- ✓ **Encounter Resubmission Tracking**

PANEL: EDI Encounter Batch Status

To check the EDI Encounter Batch Status, the Encounter Batch Summary or the Encounter Resubmission Tracking go to the Claims link and then click on the encounter data subsystem link. This opens the Encounter Data Maintenance and Navigation panel. All MCO's have access to these panels but only under their own trading partner number.

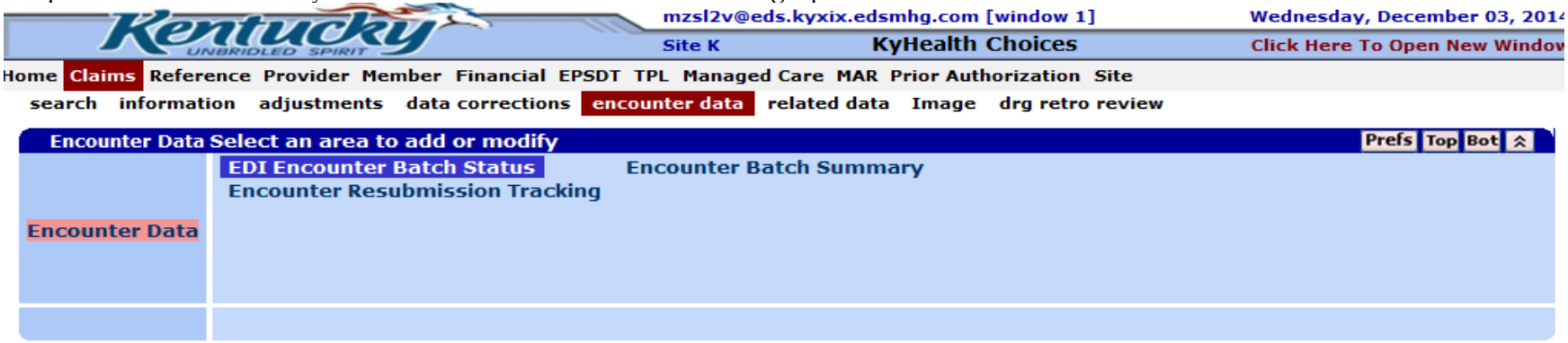


FIGURE 36 EDI Encounter Batch Status Link

FOLLOW THE STEPS

- Click on the Claims system link.
- Click on the encounter data subsystem link

To check the batch status click on the EDI Encounter Batch Status panel.

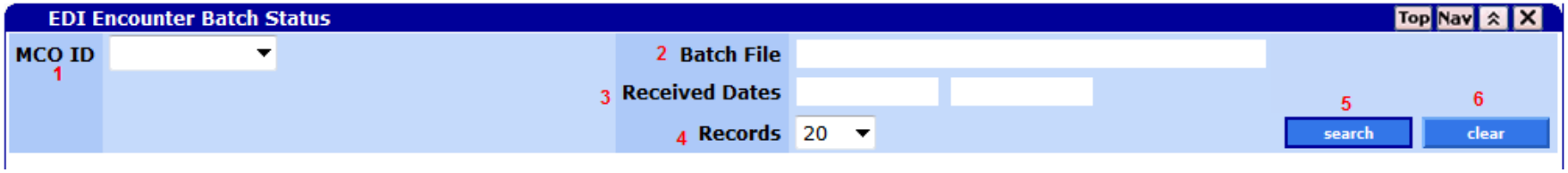


FIGURE 37 EDI Encounter Batch Status Panel

Field Descriptions

Field No.	Field	Description
1	MCO ID	The ID Number of the MCO.
2	Batch File	The batch file number.
3	Received Dates	The date range the batch file was received.
4	Records	Indicates how many records can be shown at one time.
5	Search	Initiates a claim search.
6	Clear	Clears search criteria from panel.

Choose the MCO Trading Partner ID from the drop down box, and put in a date range, and the Batch File ID if you know it.(The Batch file ID is not required)This will tell you what the status of the batch file is. Each MCO has a date that their batch files are due. They are allowed 5 days before and 5 days after the due date to submit files.

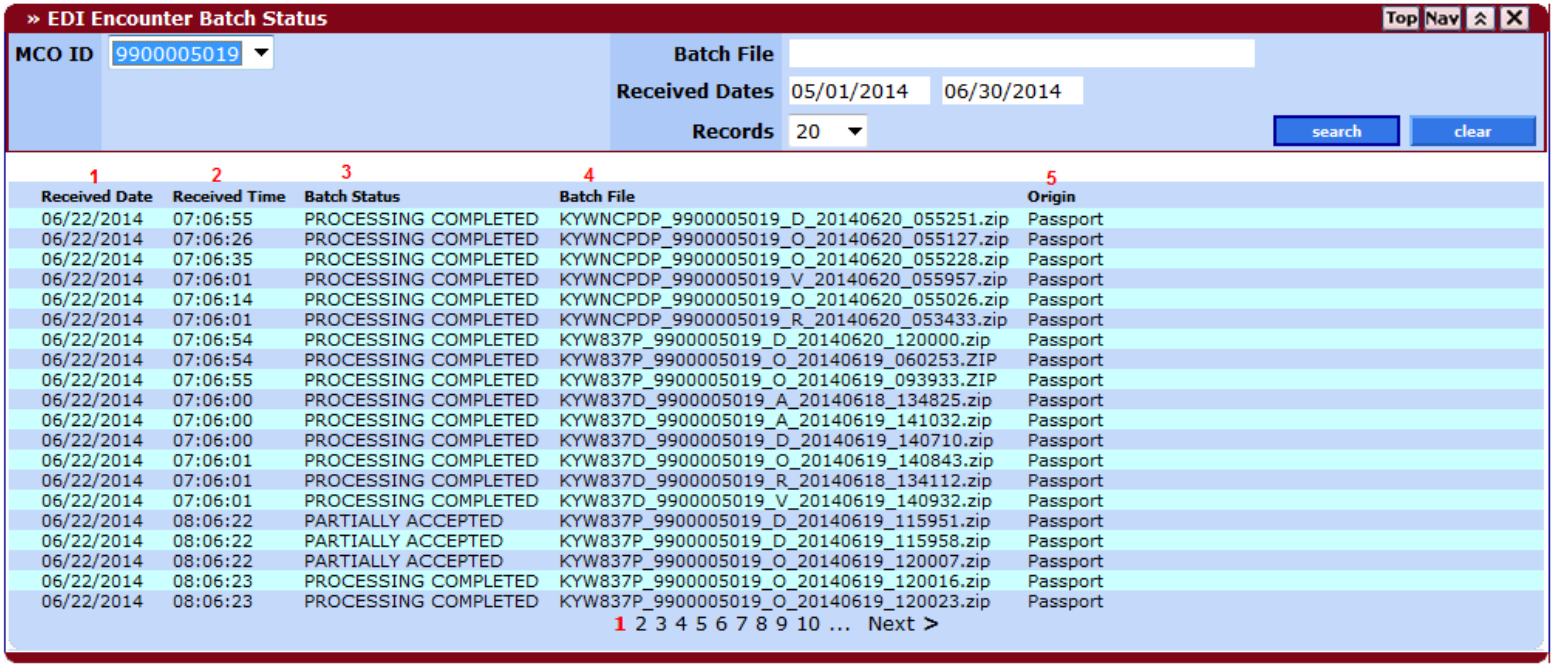


FIGURE 38 EDI Encounter Batch Status

FOLLOW THE STEPS

- **Choose the MCO Trading Partner ID from the drop down box**
- **Put in the received date range.**

Field Descriptions

Field No.	Field	Description
1	Received Date	The date the batch file was received.
2	Received Time	The time the batch file was received
3	Batch Status	The status of the Batch file.
4	Batch File	The number of the batch file.
5	Origin	Indicates which MCO sent the batch file.

Panel: Encounter Batch Summary

To see the Encounter Batch Summary for a Batch file click on the Encounter Batch Summary link in the navigation panel. In this panel you can look for all batch files within a date range, or any that were accepted, rejected or are in process. You can also see how many errors were on a file, the total encounter count and the total billed and paid amounts.

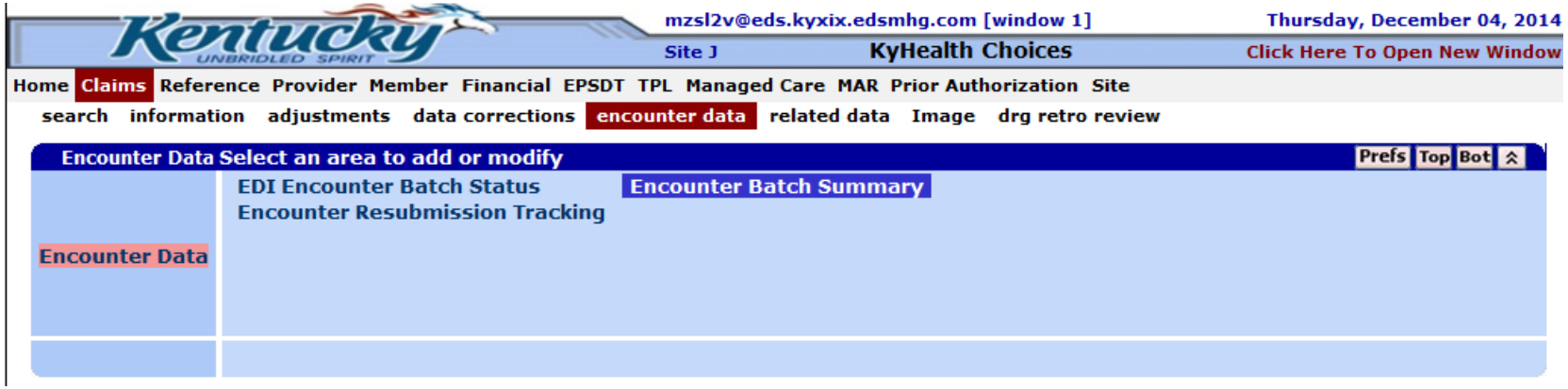


FIGURE 39 Encounter Batch Summary Link

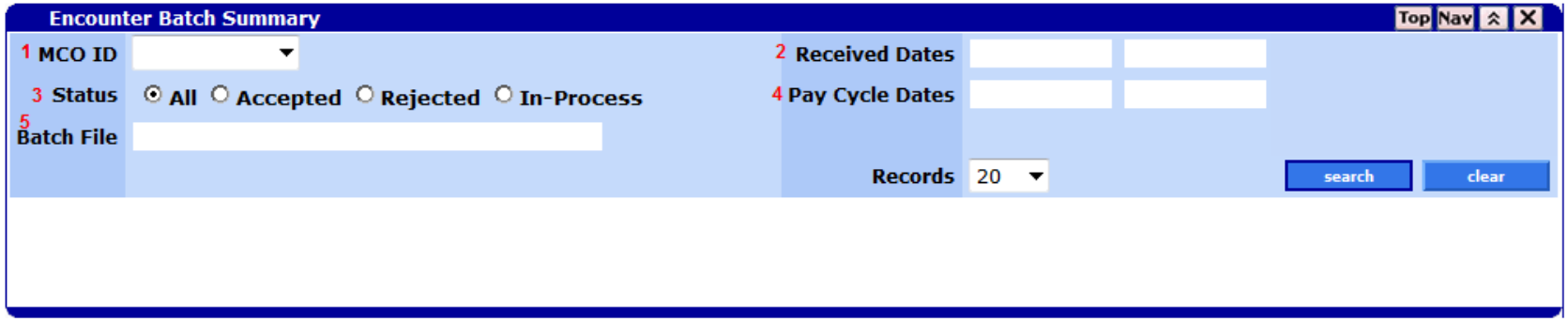


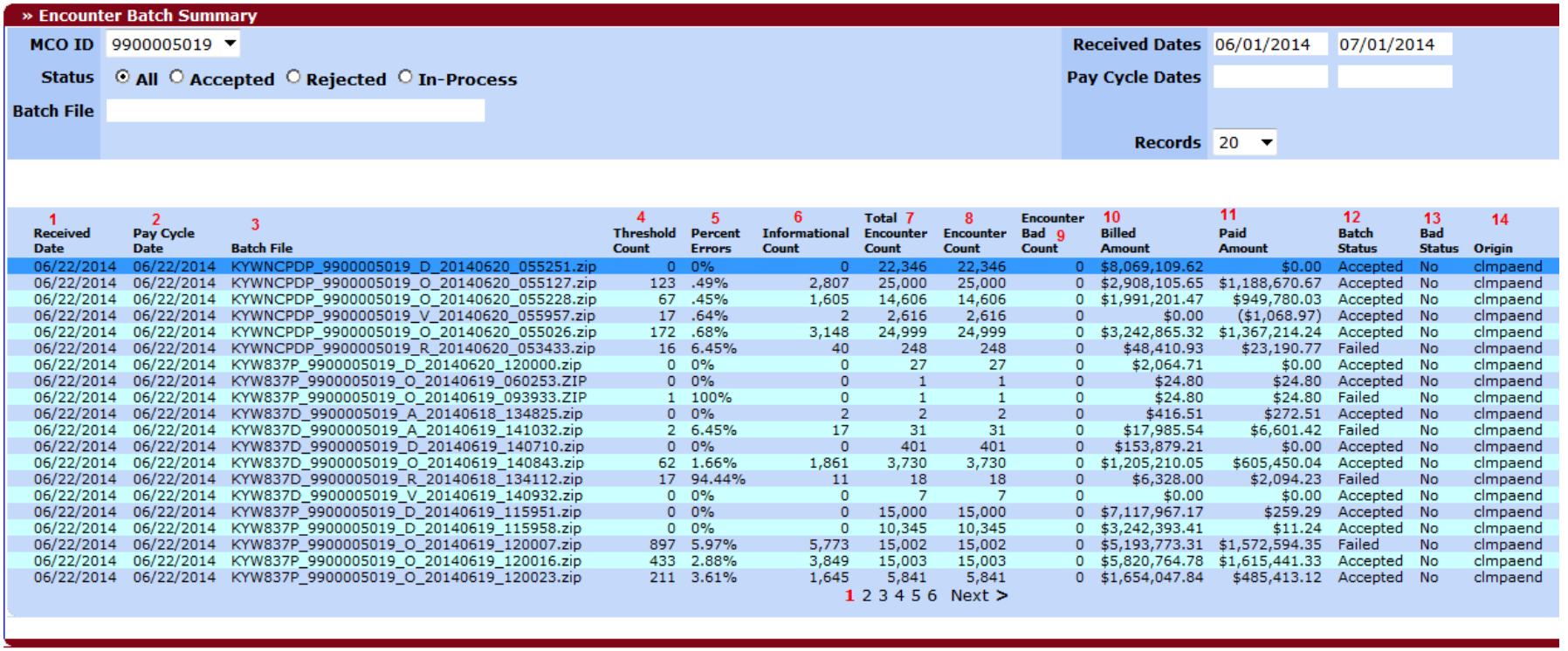
FIGURE 40 Encounter Batch Summary Panel

FOLLOW THE STEPS

- Choose the MCO Trading Partner ID from the drop down box
- Put in the received date range.
- Choose a status

Field Descriptions

Field No.	Field	Description
1	MCO ID	The Trading Partner number of the MCO.
2	Received Dates	The Dates the batch file was received
3	Status	Indicates options that can be chosen, All, Accepted, Rejected and In-Process.
4	Pay Cycle Dates	The pay cycle dates of the batch file.
5	Batch File	The number of the batch file.



» Encounter Batch Summary

MCO ID 9900005019 | Received Dates 06/01/2014 07/01/2014

Status ◉ All ○ Accepted ○ Rejected ○ In-Process | Pay Cycle Dates

Batch File | Records 20

1 Received Date	2 Pay Cycle Date	3 Batch File	4 Threshold Count	5 Percent Errors	6 Informational Count	7 Total Encounter Count	8 Encounter Count	9 Encounter Bad Count	10 Billed Amount	11 Paid Amount	12 Batch Status	13 Bad Status	14 Origin
06/22/2014	06/22/2014	KYWNCPDP_9900005019_D_20140620_055251.zip	0	0%	0	22,346	22,346	0	$8,069,109.62	$0.00	Accepted	No	clmpaend
06/22/2014	06/22/2014	KYWNCPDP_9900005019_O_20140620_055127.zip	123	.49%	2,807	25,000	25,000	0	$2,908,105.65	$1,188,670.67	Accepted	No	clmpaend
06/22/2014	06/22/2014	KYWNCPDP_9900005019_O_20140620_055228.zip	67	.45%	1,605	14,606	14,606	0	$1,991,201.47	$949,780.03	Accepted	No	clmpaend
06/22/2014	06/22/2014	KYWNCPDP_9900005019_V_20140620_055957.zip	17	.64%	2	2,616	2,616	0	$0.00	($1,068.97)	Accepted	No	clmpaend
06/22/2014	06/22/2014	KYWNCPDP_9900005019_O_20140620_055026.zip	172	.68%	3,148	24,999	24,999	0	$3,242,865.32	$1,367,214.24	Accepted	No	clmpaend
06/22/2014	06/22/2014	KYWNCPDP_9900005019_R_20140620_053433.zip	16	6.45%	40	248	248	0	$48,410.93	$23,190.77	Failed	No	clmpaend
06/22/2014	06/22/2014	KYW837P_9900005019_D_20140620_120000.zip	0	0%	0	27	27	0	$2,064.71	$0.00	Accepted	No	clmpaend
06/22/2014	06/22/2014	KYW837P_9900005019_O_20140619_060253.ZIP	0	0%	0	1	1	0	$24.80	$24.80	Accepted	No	clmpaend
06/22/2014	06/22/2014	KYW837P_9900005019_O_20140619_093933.ZIP	1	100%	0	1	1	0	$24.80	$24.80	Failed	No	clmpaend
06/22/2014	06/22/2014	KYW837D_9900005019_A_20140618_134825.zip	0	0%	2	2	2	0	$416.51	$272.51	Accepted	No	clmpaend
06/22/2014	06/22/2014	KYW837D_9900005019_A_20140619_141032.zip	2	6.45%	17	31	31	0	$17,985.54	$6,601.42	Failed	No	clmpaend
06/22/2014	06/22/2014	KYW837D_9900005019_D_20140619_140710.zip	0	0%	0	401	401	0	$153,879.21	$0.00	Accepted	No	clmpaend
06/22/2014	06/22/2014	KYW837D_9900005019_O_20140619_140843.zip	62	1.66%	1,861	3,730	3,730	0	$1,205,210.05	$605,450.04	Accepted	No	clmpaend
06/22/2014	06/22/2014	KYW837D_9900005019_R_20140618_134112.zip	17	94.44%	11	18	18	0	$6,328.00	$2,094.23	Failed	No	clmpaend
06/22/2014	06/22/2014	KYW837D_9900005019_V_20140619_140932.zip	0	0%	0	7	7	0	$0.00	$0.00	Accepted	No	clmpaend
06/22/2014	06/22/2014	KYW837P_9900005019_D_20140619_115951.zip	0	0%	0	15,000	15,000	0	$7,117,967.17	$259.29	Accepted	No	clmpaend
06/22/2014	06/22/2014	KYW837P_9900005019_D_20140619_115958.zip	0	0%	0	10,345	10,345	0	$3,242,393.41	$11.24	Accepted	No	clmpaend
06/22/2014	06/22/2014	KYW837P_9900005019_O_20140619_120007.zip	897	5.97%	5,773	15,002	15,002	0	$5,193,773.31	$1,572,594.35	Failed	No	clmpaend
06/22/2014	06/22/2014	KYW837P_9900005019_O_20140619_120016.zip	433	2.88%	3,849	15,003	15,003	0	$5,820,764.78	$1,615,441.33	Accepted	No	clmpaend
06/22/2014	06/22/2014	KYW837P_9900005019_O_20140619_120023.zip	211	3.61%	1,645	5,841	5,841	0	$1,654,047.84	$485,413.12	Accepted	No	clmpaend

1 2 3 4 5 6 Next >

FIGURE 41 Encounter Batch Summary Panel Populated

Field Descriptions

Field No.	Field	Description
1	Received Date	The date the batch file was received from the MCO.
2	Pay Cycle Date	The pay cycle date of the MCO.
3	Batch File	The number of the batch file.
4	Threshold Counts	The number of Encounters that hit thresholds in this batch file.
5	Percent Errors	The percentage of errors in the batch file.

Field Descriptions

Field No.	Field	Description
6	Informational Count	Indicates the number errors set and pay list.
7	Total Encounter Count	Indicates the total number of Encounters sent in the batch file.
8	Encounter Count	Indicates the number of Encounters sent in the batch file.
9	Encounter Bad Count	Encounters that failed in FTS and did not make it to processing.
10	Billed Amount	The amount billed by the MCO.
11	Paid Amount	The amount paid by the MCO.
12	Batch Status	The status of the batch file.
13	Bad Status	
14	Origin	

Clicking on a line will give you additional information about the errors on that batch file.

- The Encounter Errors below are associated with the selected row on the Encounter Batch Summary -

Encounter Errors

(●) All ( ) Informational ( ) Threshold

Error Code	Error Code Disposition	Error Count	Percent of Total	Error Description
2001	Threshold	23	0.76 %	MEMBER ID NUMBER NOT ON FILE RECYCLE
4007	Threshold	3	0.10 %	NON-COVERED NDC DUE TO CMS TERMINATION
4004	Threshold	1	0.03 %	NDC NOT ON FILE
5001	Threshold	40	1.33 %	EXACT DUPLICATE
1032	Threshold	5	0.17 %	BILLING PROVIDER NOT ELIGIBLE TO BILL THIS CLM TYP
2508	Informational	518	17.21 %	MEMBER COVERED BY PRIVATE INSURANCE (PHARMACY)
1970	Informational	38	1.26 %	PROV ID NO UNIQUE MATCH-BILLING PROV 5+4 ZIP
1836	Threshold	51	1.69 %	BILLING PROV NPI NOT ELIG FOR CLAIM DOS
1880	Informational	249	8.27 %	PRESCRIBER'S NPI IS NOT ON FILE
3404	Informational	2,059	68.41 %	THE BILLING PROVIDER IS NOT ENROLLED WITH THE MCO.
Total Error Count:		3,010		

1 2 Next >

FIGURE 42 Encounter Errors

Clicking on one of these lines will give you the ICN's and member ID's of the encounters that hit the error code..

- The Encounter Claims below are associated with the selected row on the Encounter Errors Panel -

Encounter Claims Related Data

ICN	Previous ICN	Member ID	Status	Claim Type	FDOS	TDOS	Paid Date	Amount Billed
780000000000		0000000000	PAID	PHARMACY CLAIMS	06/09/2014	06/09/2014	0	$22.62
780000000000		0000000000	PAID	PHARMACY CLAIMS	06/07/2014	06/07/2014	0	$125.91
780000000000		0000000000	PAID	PHARMACY CLAIMS	06/09/2014	06/09/2014	0	$6.63
780000000000		0000000000	PAID	PHARMACY CLAIMS	06/07/2014	06/07/2014	0	$7.12
780000000000		0000000000	PAID	PHARMACY CLAIMS	06/07/2014	06/07/2014	0	$164.26
780000000000		0000000000	PAID	PHARMACY CLAIMS	06/08/2014	06/08/2014	0	$81.52
780000000000		0000000000	PAID	PHARMACY CLAIMS	06/06/2014	06/06/2014	0	$40.93
780000000000		0000000000	PAID	PHARMACY CLAIMS	06/09/2014	06/09/2014	0	$14.02
780000000000		0000000000	PAID	PHARMACY CLAIMS	06/09/2014	06/09/2014	0	$6.63
780000000000		0000000000	PAID	PHARMACY CLAIMS	06/09/2014	06/09/2014	0	$132.10

1 2 3 4 5 Next >

FIGURE 43 Encounter Error ICN's

Panel: Encounter Resubmission Tracking

To see Encounters that have been resubmitted within a certain date range click on the Encounter Resubmission Tracking in the navigation panel. This panel allows you to see claims that have been resubmitted within that date range.

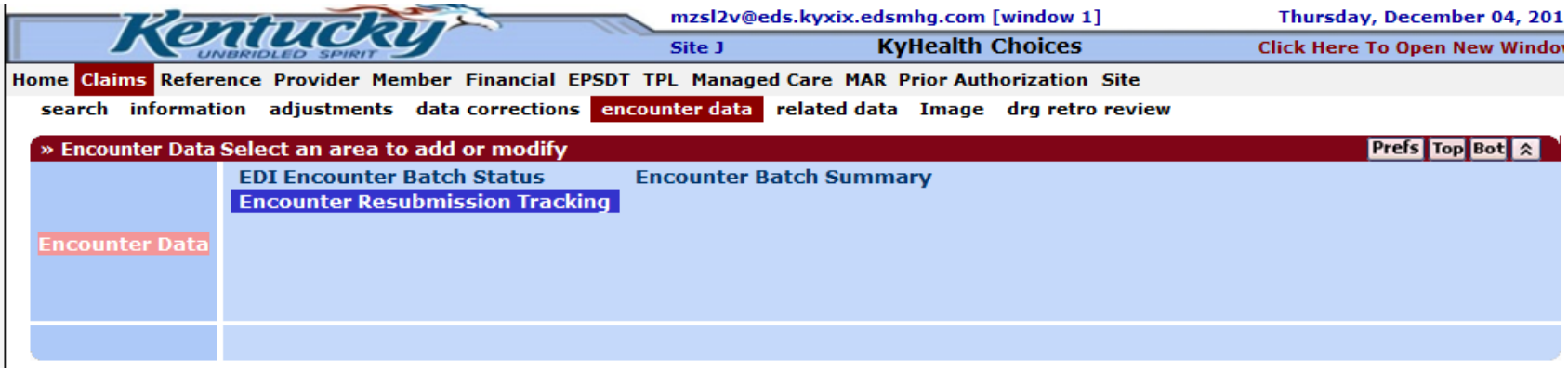


FIGURE 44 Encounter Resubmission Tracking Link

FOLLOW THE STEPS

- Click on Encounter Resubmission Tracking

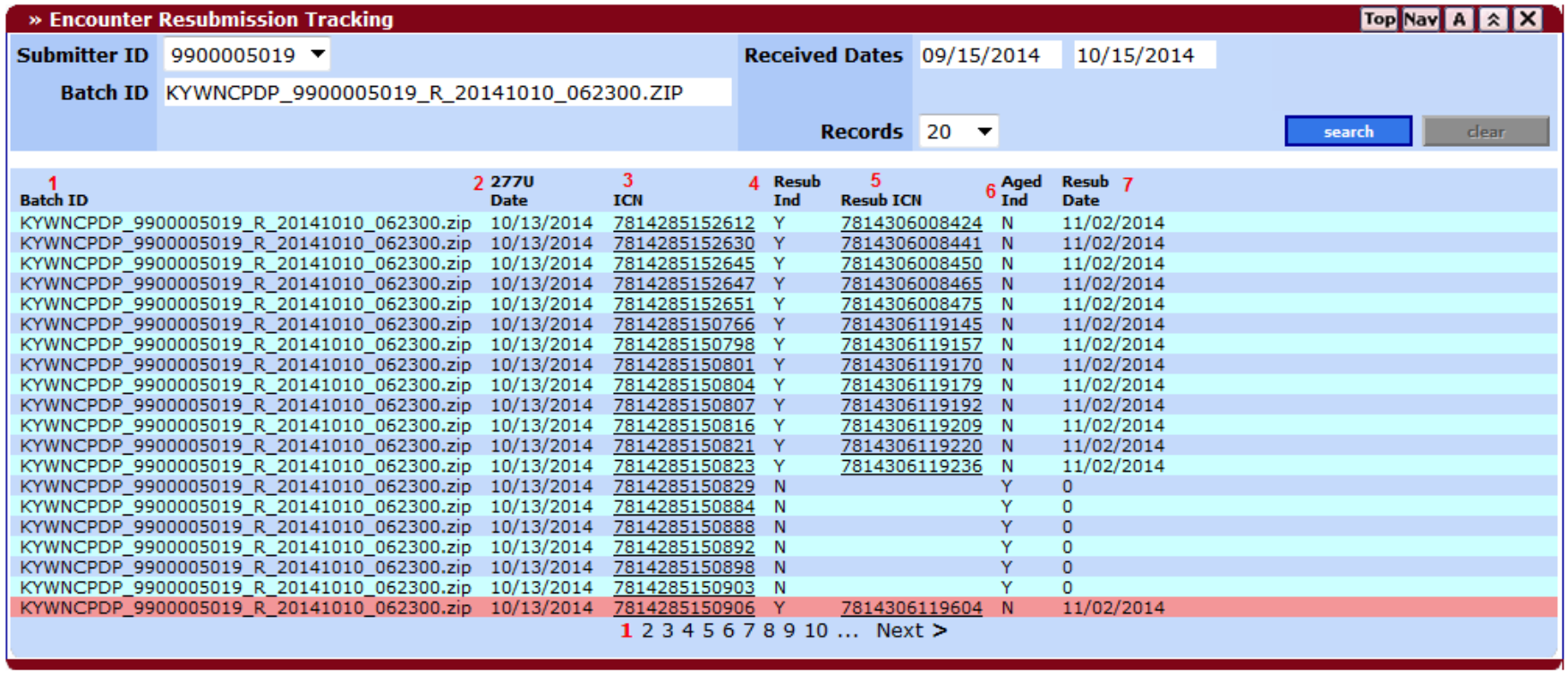


FIGURE 45 Encounter Resubmission Tracking Panel

Field Descriptions

Field No.	Field	Description
1	Batch ID	The ID number of the Batch file
2	277U Date	The date the 277U response was sent
3	ICN	The original ICN that hit the threshold.
4	Resubmission Indicator	Indicates if the Encounter was resubmitted.
5	Resubmission ICN	The ICN of the resubmitted Encounter.
6	Aged Indicator	Indicates if the Encounter has aged or not.
7	Resubmission Date	The date the encounter was resubmitted.

Threshold Edits

277U Status Code	277U Status Code Description	Encounter Threshold Error	Encounter Threshold Error Description (See Edit Manual for Specifics)	MMIS EOB	MMIS EOB Description
562	Entity's National Provider Identifier (NPI).	201	Invalid Provider Number	2244	INVALID PAY-TO PROVIDER NUMBER
26	Entity not found	202	BILLING PROVIDER ID IN INVALID FORMAT	2123	INVALID/MISSING PAY-TO PROVIDER CHECK-DIGIT NUMBER
97	Patient eligibility not found with entity.	203	RECIPIENT I.D. NUMBER MISSING	2439	LTC MISS MEMBER ID NUMBER
91	Entity not eligible/not approved for dates of service.	206	PRESC PRACT LICENSE NUMBER NOT IN VALID FORMAT	206	PRESC PRACT LICENSE NUMBER NOT IN VALID FORMAT
104	Processed according to plan provisions	213	DATE PRESCRIBED IS MISSING	9999	PROCESSED PER MEDICAID POLICY
104	Processed according to plan provisions	215	DATE DISPENSED IS MISSING	9999	PROCESSED PER MEDICAID POLICY
218	NDC number	217	NDC MISSING	2152	MISSING DRUG CODE
258	Days/units for procedure/revenue code.	219	QUANTITY DISPENSED IS MISSING	2155	MISSING DRUG QUANTITY
26	Entity not found	231	RENDERING PROVIDER NUMBER IS MISSING	2121	CLAIM WAS FILED WITHOUT SERVICING PROVIDER
121	Service line number greater than maximum allowable for p	247	MAXIMUM NUMBER OF CLAIM DETAILS EXCEEDED	2247	MAXIMUM NUMBER OF CLAIM DETAILS EXCEEDED
247	Line information.	250	CLAIM HAS NO DETAILS	2249	CLAIM HAS NO DETAILS
562	Entity's National Provider Identifier (NPI).	259	DATE BILLED IS MISSING/INVALID	1000	INDIVIDUAL/BILLING PROVIDER(GROUP)/NPI NUMBER(S) BILLED INCORRECTLY OR NOT ON F
242	Tooth numbers, surfaces, and/or quadrants involved.	261	TOOTH NUMBER MISSING	2182	MISSING TOOTH NUMBER
178	Submitted charges.	271	HEADER TOTAL BILLED AMOUNT INVALID	2133	INVALID TOTAL CLAIM CHARGE
228	Type of bill for UB claim	273	TYPE OF BILL MISSING	2138	MISSING/INVALID TYPE OF BILL
228	Type of bill for UB claim	274	TYPE OF BILL CODE INVALID	977	TYPE OF BILL INVALID FOR PROVIDER TYPE.
228	Type of bill for UB claim	274	TYPE OF BILL CODE INVALID	2138	MISSING/INVALID TYPE OF BILL
584	Line Item Control Number	350	NO. OF DETAILS NOT EQUAL TO SUBMITTED DETAIL COUNT	2350	THE NUMBER OF DETAILS IS NOT EQUAL TO THE SUBMITTED DETAIL COUNT.
187	Date(s) of service.	395	HEADER STATEMENT COVERS PERIOD "FROM" DATE MISSING	2124	MISSING FIRST DATE OF SERVICE ON CLAIM
187	Date(s) of service.	396	HEADER STATEMENT COVERS PERIOD "FROM" DATE INVALID	2124	MISSING FIRST DATE OF SERVICE ON CLAIM
456	Covered Day(s)	397	HEADER STMT COVERS PERIOD "THROUGH" DATE MISSING	2193	MISSING COVERED DAYS
104	Processed according to plan provisions	398	STATEMENT COVERS PERIOD "THROUGH" DATE INVALID	9999	PROCESSED PER MEDICAID POLICY
476	Missing or invalid units of service	400	DETAIL UNITS OF SERVICE MUST BE GREATER THAN ZERO	30	CLAIM/DETAIL DENIED. DETAIL NUMBER OF SERVICES MISSING.
476	Missing or invalid units of service	400	DETAIL UNITS OF SERVICE MUST BE GREATER THAN ZERO	2183	MISSING UNITS OF SERVICE
87	Denied: Entity not found.	1000	BILLING PROVIDER I.D. NUMBER NOT 0N FILE	2308	NO PAY-TO PROVIDER RECORD
132	Entity not eligible/not approved for dates of service.	1003	BILLING PROV NOT ELIG AT SERV LOC FOR PROG BILLED	2681	PROVIDER INELIGIBLE ON DATE OF SERVICE
109	Entity not eligible.	1007	RENDERING PROVIDER I.D. NOT ON FILE	2300	NO PROVIDER MASTER RECORD
276	INVALID PROVIDER TYPE BILLED ON CLAIM FORM.	1032	BILLING PROVIDER NOT ELIGIBLE TO BILL THIS CLM TYP	409	INVALID PROVIDER TYPE BILLED ON CLAIM FORM.
276	INVALID PROVIDER TYPE BILLED ON CLAIM FORM.	1036	RENDERING PROV TYPE/CLAIM TYPE INVALID	409	INVALID PROVIDER TYPE BILLED ON CLAIM FORM.
109	Entity not eligible.	1051	RENDERING PROVIDER NOT ON PROVIDER DATABASE (HDR)	2300	NO PROVIDER MASTER RECORD
562	Entity's National Provider Identifier (NPI).	1836	BILLING PROV NPI NOT ELIG FOR CLAIM DOS	1836	BILLING PROV NPI NOT ELIG FOR CLAIM DOS
145	Entity's specialty/taxonomy code.	1853	HEADER RENDERING PROVIDER TAXONOMY INVALID	1853	HEADER RENDERING PROVIDER TAXONOMY INVALID
145	Entity's specialty/taxonomy code.	1856	DETAIL RENDERING PROVIDER TAXONOMY INVALID	1856	DETAIL RENDERING PROVIDER TAXONOMY INVALID
145	Entity's specialty/taxonomy code.	1857	BILLING PROVIDER TAXONOMY INVALID FOR DATE OF SERVICE	1857	BILLING PROVIDER TAXONOMY INVALID FOR DATE OF SERVICE

145	Entity's specialty/taxonomy code.	1858	HEADER RENDERING PROVIDER TAXONOMY INVALID FOR DATE OF SERVICE	1858	HEADER RENDERING PROVIDER TAXONOMY INVALID FOR DATE OF SERVICE
145	Entity's specialty/taxonomy code.	1861	DETAIL RENDERING PROVIDER TAXONOMY INVALID FOR DATE OF SERVICE	1861	DETAIL RENDERING PROVIDER TAXONOMY INVALID FOR DATE OF SERVICE
145	Entity's specialty/taxonomy code.	1862	BILLING PROVIDER TAXONOMY NOT VALID FOR PROVIDER	1862	BILLING PROVIDER TAXONOMY NOT VALID FOR PROVIDER
145	Entity's specialty/taxonomy code.	1863	HEADER RENDERING PROVIDER TAXONOMY INVALID FOR PROVIDER	1863	HEADER RENDERING PROVIDER TAXONOMY INVALID FOR PROVIDER
145	Entity's specialty/taxonomy code.	1866	DETAIL RENDERING PROVIDER TAXONOMY INVALID FOR PROVIDER	1866	DETAIL RENDERING PROVIDER TAXONOMY INVALID FOR PROVIDER
132	Entity's Medicaid provider id	1878	PRESCRIBER'S NPI IS INVALID	1878	PRESCRIBER'S NPI IS INVALID
132	Entity's Medicaid provider id	1879	PRESCRIBER'S NPI IS MISSING	1879	PRESCRIBER'S NPI IS MISSING
145	Entity's specialty/taxonomy code.	1881	BILLING PROVIDER TAXONOMY IS MISSING	1881	BILLING PROVIDER TAXONOMY IS MISSING
145	Entity's specialty/taxonomy code.	1882	RENDERING PROVIDER TAXONOMY IS MISSING	1882	RENDERING PROVIDER TAXONOMY IS MISSING
145	Entity's specialty/taxonomy code.	1908	NPI ONLY SUBMITTED ON CLAIM - NOT ON FILE - HDR	3360	TAXONOMY CODE INVALID
145	Entity's specialty/taxonomy code.	1910	NPI ONLY SUBMITTED - NOT ELIGIBLE FOR DOS - HDR	3360	TAXONOMY CODE INVALID
145	Entity's specialty/taxonomy code.	1911	NPI ONLY SUBMITTED - NOT ELIGIBLE FOR DOS - DTL	3360	TAXONOMY CODE INVALID
145	Entity's specialty/taxonomy code.	1955	CANNOT DETERMINE MEDICAID NBR FOR BILLING PROVIDER	1955	CANNOT DETERMINE MEDICAID NBR FOR BILLING PROVIDER
109	Entity not eligible.	2001	MEMBER ID NUMBER NOT ON FILE RECYCLE	2258	MEMBER IS NOT ON ELIGIBILITY FILE
97	Patient eligibility not found with entity.	2003	MEMBER INELIGIBLE ON DETAIL DATE OF SERVICE	2003	MEMBER INELIGIBLE ON DETAIL DATE OF SERVICE
198	Medicare effective date.	2502	OUR RECORDS INDICATE MEMBER HAS MEDICARE PART B, PLEASE E	2502	OUR RECORDS INDICATE MEMBER HAS MEDICARE PART B, PLEASE BILL MEDICARE.
499	No rate on file with the payer for this service for this entity Note: This code requires use of an Entity Code.	3310	REIMBURSEMENT RATE RECORD NOT FOUND FOR PROVIDER	368	REIMBURSEMENT RATE RECORD NOT FOUND FOR PROVIDER
218	NDC number.	4004	NDC NOT ON FILE	2360	THIS NATIONAL DRUG CODE IS NOT ON FILE
218	NDC number.	4007	NON-COVERED NDC DUE TO CMS TERMINATION	2356	NDC IS DEACTIVED AND NOT PAYABLE ON DATE FILLED
454	Procedure code for services rendered	4402	THE NDC IS MISSING OR NOT VALID FOR THIS J-CODE	4402	THE NDC IS MISSING OR IS NOT VALID FOR THIS J-CODE
402	Amount must be greater than zero	4419	MCO PAID AMOUNT MISSING OR NOT GREATER THAN ZERO	4419	MCO PAID AMOUNT MISSING OR NOT GREATER THAN ZERO
714	MEMBER MANAGED CARE REGION CODE MISSING OI	4420	MEMBER MANAGED CARE REGION CODE MISSING OR INVALID.	4420	MEMBER MANAGED CARE REGION CODE MISSING OR INVALID
91	Entity not eligible/not approved for dates of service.	4421	ENCOUNTER SUBMITTER ID INVALID FOR THE DATE OF SERVICE	4421	ENCOUNTER SUBMITTER ID INVALID FOR THE DATE OF SERVICE
54	Duplicate of a previously processed claim/line.	5001	EXACT DUPLICATE	5001	THIS IS A DUPLICATE OF ANOTHER CLAIM.
124	Entity's name, address, phone and id number	9018	837 ADJ ERR - MEMBER MEDICAID ID NOT PRESENT	9018	837 ADJ ERR - MEMBER MEDICAID ID NOT PRESENT
131	Entity's Medicare provider id.	9019	837 ADJ ERR - XOVER PROVIDER ID NOT PRESENT	9019	837 ADJ ERR - XOVER PROVIDER ID NOT PRESENT
132	Entity's Medicaid provider id	9020	837 ADJ ERR - PROVIDER ID NOT PRESENT	9020	837 ADJ ERR - PROVIDER ID NOT PRESENT
35	Claim/encounter not found.	9021	837 ADJ ERR - UNABLE TO FIND ORIGINAL ICN	9021	837 ADJ ERR - UNABLE TO FIND ORIGINAL ICN
736	A related or qualifying service/claim has not been receive	9022	837 ERR - Cannot Adjust/Void a thresholded Encounter	9022	You cannot adjust or void a thresholded encounter
124	Entity's name, address, phone and id number	9023	837 ADJ ERR - RECIPIENT NOT FOUND	9023	837 ADJ ERR - RECIPIENT NOT FOUND
132	Entity's Medicaid provider id	9024	837 ADJ ERR - PROVIDER NOT FOUND	9024	837 ADJ ERR - PROVIDER NOT FOUND
35	Claim/encounter not found.	9025	837 ADJ ERR - ORIGINAL CLAIM NOT FOUND	9025	837 ADJ ERR - ORIGINAL CLAIM NOT FOUND
495	Requests for re-adjudication must reference the newly ass	9026	837 ADJ ERR - CLAIM HAS BEEN ADJUSTED	9026	837 ADJ ERR - CLAIM HAS BEEN ADJUSTED
495	Requests for re-adjudication must reference the newly ass	9027	837 ADJ ERR - CLM ALREADY SCHEDULED TO BE ADJUSTED	9027	837 ADJ ERR - CLM ALREADY SCHEDULED TO BE ADJUSTED
145	Entity's specialty/taxonomy code.	9028	ADJ ERR-PROV TAXONOMY/ZIP NOT MATCHING ORIGINAL	9028	ADJ ERR-PROV TAXONOMY/ZIP NOT MATCHING ORIGINAL
481	CLAIM/SUBMISSION FORMAT IS INVALID	9029	ADJ - CURRENT CLAIM TYPE NOT MATCHING ORIGIN	9029	ADJ - CURRENT CLAIM TYPE NOT MATCHING ORIGIN
480	Entity's claim filing indicator.	4430	ENCOUNTER DATA TYPE INVALID FOR FILE TYPE	4430	THE ENCOUNTER DATA TYPE SUBMITTED IS NOT ACCEPTABLE FOR THE FILE TYPE.

TA1 Codes

000 No Error	**016** Invalid Interchange Standards Identifier Value
001 The Interchange Control Number In The Header and Trailer Do Not Match. The Value From The Header Is Used In The Acknowledgement	**017** Invalid Interchange Version ID Value
002 This Standard As Noted In The Control Standards Identifier Is Not Supported	**018** Invalid Interchange Control Number Value
003 This Version Of The Controls Is Not Supported	**019** Invalid Acknowledgement Requested Value
004 The Segment Terminator Is Invalid	**020** Invalid Test Indicator Value
005 Invalid Interchange ID Qualifier For Sender	**021** Invalid Number Of Included Groups Value
006 Invalid Interchange Sender ID	**022** Invalid Control Structure
007 Invalid Interchange ID Qualifier For Receiver	**023** Improper (Premature)End-of-File (Transmission)
008 Invalid Interchange Receiver ID	**024** Invalid Interchange Content (e.g., Invalid GS Segment)
009 Unknown Interchange Receiver ID	**025** Duplicate Interchange Control Number
010 Invalid Authorization Information Qualifier Value	**026** Invalid Data Element Separator
011 Invalid Authorization Information Value	**027** Invalid Component Element Separator
012 Invalid Security Information Qualifier Value	**028** Invalid Delivery Date In Deferred Delivery Request
013 Invalid Security Information Value	**029** Invalid Delivery Time In Deferred Delivery Request
014 Invalid Interchange Data Value	**030** Invalid Delivery Time Code In Deferred Delivery Request
015 Invalid Interchange Time Value	**031** Invalid Grade Of Service Code

Adjustment Reason Codes

HIPAA requires that every "adjustment" to the allowed price of a claim that causes it to differ from the amount originally billed on the claim should be accounted for. As a result, all cutbacks/denials of units and dollars need to be captured and mapped to HIPAA specific adjustment reason codes and remarks codes.

1	Deductible Amount
10	The diagnosis is inconsistent with the patient's gender.
100	Payment made to patient/insured/responsible party.
101	Predetermination: anticipated payment upon completion of services or claim adjudication.
102	Major Medical Adjustment.
103	Provider promotional discount (e.g., Senior citizen discount).
104	Managed care withholding.
105	TAX WITHHOLDING.
106	PATIENT PAYMENT OPTION/ELECTION NOT IN EFFECT.
107	Claim/service denied because the related or qualifying claim/service was not paid or identified on the claim.
108	Payment reduced because rent/purchase guidelines were not met.
109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
11	The diagnosis is inconsistent with the procedure.
110	BILLING DATE PREDATES SERVICE DATE.
111	Not covered unless the provider accepts assignment.
112	Payment adjusted as not furnished directly to the patient and/or not documented.
113	Payment denied because service/procedure was provided outside the United States or as a result of war.
114	Procedure/product not approved by the Food and Drug Administration.
115	Payment adjusted as procedure postponed or canceled.
116	Payment denied. The advance indemnification notice signed by the patient did not comply with requirements.
117	Payment adjusted because transportation is only covered to the closest facility that can provide the necessary care.

118	CHARGES REDUCED FOR ESRD NETWORK SUPPORT.
119	Benefit maximum for this time period has been reached.
12	The diagnosis is inconsistent with the provider type.
120	Patient is covered by a managed care plan.
121	Indemnification adjustment.
122	PSYCHIATRIC REDUCTION.
123	Payer refund due to overpayment.
124	Payer refund amount - not our patient.
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes whenever appropriate.
126	Deductible -- Major Medical
127	Coinsurance -- Major Medical
128	Newborn's services are covered in the mother's Allowance.
129	Payment denied - Prior processing information appears incorrect.
13	The date of death precedes the date of service.
130	Claim submission fee.
131	Claim specific negotiated discount.
132	Prearranged demonstration project adjustment.
133	The disposition of this claim/service is pending further review.
134	Technical fees removed from charges.
135	Claim denied. Interim bills cannot be processed.
136	Claim Adjusted. Plan procedures of a prior payer were not followed.
137	Payment/Reduction for Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.
138	Claim/service denied. Appeal procedures not followed or time limits not met.
139	Contracted funding agreement - Subscriber is employed by the provider of services.
14	The date of birth follows the date of service.
140	Patient/Insured health identification number and name do not match.
141	Claim adjustment because the claim spans eligible and ineligible periods of coverage.
142	Claim adjusted by the monthly Medicaid patient liability amount.
143	Portion of payment deferred.
144	Incentive adjustment, e.g. preferred product/service.
145	Premium payment withholding
146	Payment denied because the diagnosis was invalid for the date(s) of service reported.
147	Provider contracted/negotiated rate expired or not on file.
148	Claim/service rejected at this time because information from another provider was not provided or was insufficient/incomplete.

149	Lifetime benefit maximum has been reached for this service/benefit category.
15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.
150	Payment adjusted because the payer deems the information submitted does not support this level of service.
151	Payment adjusted because the payer deems the information submitted does not support this many services.
152	Payment adjusted because the payer deems the information submitted does not support this length of service.
153	Payment adjusted because the payer deems the information submitted does not support this dosage.
154	Payment adjusted because the payer deems the information submitted does not support this day's supply.
155	This claim is denied because the patient refused the service/procedure.
156	Flexible spending account payments
157	Payment denied/reduced because service/procedure was provided as a result of an act of war.
158	Payment denied/reduced because the service/procedure was provided outside of the United States.
159	Payment denied/reduced because the service/procedure was provided as a result of terrorism.
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate
160	Payment denied/reduced because injury/illness was the result of an activity that is a benefit exclusion.
161	Provider performance bonus
162	State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation.
163	Claim/Service adjusted because the attachment referenced on the claim was not received.
164	Claim/Service adjusted because the attachment referenced on the claim was not received in a timely fashion.
165	Payment denied /reduced for absence of, or exceeded referral
166	These services were submitted after this payers responsibility for processing claims under this plan ended.
167	This (these) diagnosis(es) is (are) not covered.
168	Payment denied as Service(s) have been considered under the patient's medical plan. Benefits are not available under this dental plan
169	Payment adjusted because an alternate benefit has been provided
17	Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate.
170	Payment is denied when performed/billed by this type of provider.
171	Payment is denied when performed/billed by this type of provider in this type of facility.
172	Payment is adjusted when performed/billed by a provider of this specialty
173	Payment adjusted because this service was not prescribed by a physician
174	Payment denied because this service was not prescribed prior to delivery
175	Payment denied because the prescription is incomplete
176	Payment denied because the prescription is not current

177	Payment denied because the patient has not met the required eligibility requirements
178	Payment adjusted because the patient has not met the required spend down requirements.
179	Payment adjusted because the patient has not met the required waiting requirements
18	Duplicate claim/service.
180	Payment adjusted because the patient has not met the required residency requirements
181	Payment adjusted because this procedure code was invalid on the date of service
182	Payment adjusted because the procedure modifier was invalid on the date of service
183	The referring provider is not eligible to refer the service billed.
184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.
185	The rendering provider is not eligible to perform the service billed.
186	Payment adjusted since the level of care changed
187	Health Savings account payments
188	This product/procedure is only covered when used according to FDA recommendations.
189	"Not otherwise classified" or "unlisted" procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service
19	Claim denied because this is a work-related injury/illness and thus the liability of the Workers Compensation Carrier.
190	Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay.
191	Claim denied because this is not a work related injury/illness and thus not the liability of the workers? compensation carrier.
192	Non standard adjustment code from paper remittance advice.
193	Original payment decision is being maintained. This claim was processed properly the first time.
194	Payment adjusted when anesthesia is performed by the operating physician, the assistant surgeon or the attending physician
195	Payment denied/reduced due to a refund issued to an erroneous priority payer for this claim/service
196	Claim/service denied based on prior payer's coverage determination.
197	Payment denied/reduced for absence of precertification/authorization
198	Payment denied/reduced for exceeded, precertification/authorization
199	Revenue code and Procedure code do not match.
2	Coinsurance Amount
20	Claim denied because this injury/illness is covered by the liability carrier.
200	Expenses incurred during lapse in coverage
201	Workers Compensation case settled. Patient is responsible for amount of this claim/service through WC ?Medicare set aside arrangement? or other agreement. (Use group code PR).
208	NPI denial - not matched
21	Claim denied because this injury/illness is the liability of the no-fault carrier.

22	Payment adjusted because this care may be covered by another payer per coordination of benefits.
23	Payment adjusted because charges have been paid by another payer.
24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.
25	Payment denied. Your Stop loss deductible has not been met.
26	Expenses incurred prior to coverage.
27	Expenses incurred after coverage terminated.
28	Coverage not in effect at the time the service was provided.
29	The time limit for filing has expired.
3	Co-payment Amount
30	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.
31	Claim denied as patient cannot be identified as our insured.
32	Our records indicate that this dependent is not an eligible dependent as defined.
33	Claim denied. Insured has no dependent coverage.
34	Claim denied. Insured has no coverage for newborns.
35	Benefit maximum has been reached.
36	Balance does not exceed co-payment amount.
37	BALANCE DOES NOT EXCEED DEDUCTIBLE.
38	Services not provided or authorized by designated (network) providers.
39	Services denied at the time authorization/pre-certification was requested.
4	The procedure code is inconsistent with the modifier used or a required modifier is missing.
40	Charges do not meet qualifications for emergent/urgent care.
41	Discount agreed to in Preferred Provider contract.
42	Charges exceed our fee schedule or maximum allowable amount.
43	Gramm-Rudman reduction.
44	Prompt-pay discount.
45	Charges exceed your contracted/ legislated fee arrangement.
46	This (these) service(s) is (are) not covered.
47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.
48	This (these) procedure(s) is (are) not covered.
49	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.
5	The procedure code/bill type is inconsistent with the place of service.
50	These are non-covered services because this is not deemed a 'medical necessity' by the payer.
51	These are non-covered services because this is a pre-existing condition
52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.

53	Services by an immediate relative or a member of the same household are not covered.
54	Multiple physicians/assistants are not covered in this case .
55	Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer.
56	Claim/service denied because procedure/treatment has not been deemed 'proven to be effective' by the payer.
57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.
58	Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.
59	Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.
6	The procedure code is inconsistent with the patient's age.
60	Charges for outpatient services with this proximity to inpatient services are not covered.
61	Charges adjusted as penalty for failure to obtain second surgical opinion.
62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.
63	Correction to a prior claim.
64	Denial reversed per Medical Review.
65	Procedure code was incorrect. This payment reflects the correct code.
66	Blood Deductible.
67	Lifetime reserve days. (Handled in QTY, QTY01=LA)
68	DRG weight. (Handled in CLP12)
69	Day outlier amount.
7	The procedure code is inconsistent with the patient's gender.
70	Cost outlier - Adjustment to compensate for additional costs.
71	Primary Payer amount.
72	Coinsurance day. (Handled in QTY, QTY01=CD)
73	Administrative days.
74	Indirect Medical Education Adjustment.
75	Direct Medical Education Adjustment.
76	Disproportionate Share Adjustment.
77	Covered days. (Handled in QTY, QTY01=CA)
78	Non-Covered days/Room charge adjustment.
79	Cost Report days. (Handled in MIA15)
8	The procedure code is inconsistent with the provider type.
80	Outlier days. (Handled in QTY, QTY01=OU)
81	Discharges.
82	PIP days.
83	Total visits.

84	Capital Adjustment. (Handled in MIA)
85	Interest amount.
86	Statutory Adjustment.
87	Transfer amount.
88	Adjustment amount represents collection against receivable created in prior overpayment.
89	Professional fees removed from charges.
9	The diagnosis is inconsistent with the patient's age.
90	Ingredient cost adjustment.
91	Dispensing fee adjustment.
92	Claim Paid in full.
93	No Claim level Adjustments.
94	Processed in Excess of charges.
95	Benefits adjusted. Plan procedures not followed.
96	Non-covered charge(s).
97	Payment is included in the allowance for another service/procedure.
98	The hospital must file the Medicare claim for this inpatient non-physician service.
99	Medicare Secondary Payer Adjustment Amount.
A0	Patient refund amount.
A1	Claim denied charges.
A2	Contractual adjustment.
A3	Medicare Secondary Payer liability met.
A4	Medicare Claim PPS Capital Day Outlier Amount.
A5	Medicare Claim PPS Capital Cost Outlier Amount.
A6	Prior hospitalization or 30 day transfer requirement not met.
A7	Presumptive Payment Adjustment
A8	Claim denied; ungroupable DRG
B1	NON-COVERED VISITS.
B10	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.
B11	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.
B12	Services not documented in patients' medical records.
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.
B14	Payment denied because only one visit or consultation per physician per day is covered.
B15	Payment adjusted because this procedure/service is not paid separately.
B16	Payment adjusted because `New Patient' qualifications were not met.

B17	Payment adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.
B18	Payment denied because this procedure code/modifier was invalid on the date of service or claim submission.
B19	Claim/service adjusted because of the finding of a Review Organization.
B2	Covered visits.
B20	Payment adjusted because procedure/service was partially or fully furnished by another provider.
B21	The charges were reduced because the service/care was partially furnished by another physician.
B22	This payment is adjusted based on the diagnosis.
B23	Payment denied because this provider has failed an aspect of a proficiency testing program.
B3	Covered charges.
B4	Late filing penalty.
B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.
B6	This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this of provider in this type of facility, or by a provider of this specialty.
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.
B8	Claim/service not covered/reduced because alternative services were available, and should have been utilized.
B9	Services not covered because the patient is enrolled in a Hospice.
D1	Claim/service denied. Level of subluxation is missing or inadequate.
D10	Claim/service denied. Completed physician financial relationship form not on file.
D11	Claim lacks completed pacemaker registration form.
D12	Claim/service denied. Claim does not identify who performed the purchased diagnostic test or the amount you were charged for the test.
D13	Claim/service denied. Performed by a facility/supplier in which the ordering/referring physician has a financial interest.
D14	Claim lacks indication that plan of treatment is on file.
D15	Claim lacks indication that service was supervised or evaluated by a physician.
D16	Claim lacks prior payer payment information.
D17	Claim/Service has invalid non-covered days.
D18	Claim/Service has missing diagnosis information.
D19	Claim/Service lacks Physician/Operative or other supporting documentation
D2	Claim lacks the name, strength, or dosage of the drug furnished.
D20	Claim/Service missing service/product information.
D21	This (these) diagnosis(es) is (are) missing or are invalid
D3	Claim/service denied because information to indicate if the patient owns the equipment that requires the part or supply was missing.
D4	Claim/service does not indicate the period of time for which this will be needed.

D5	Claim/service denied. Claim lacks individual lab codes included in the test.
D6	Claim/service denied. Claim did not include patient's medical record for the service.
D7	Claim/service denied. Claim lacks date of patient's most recent physician visit.
D8	Claim/service denied. Claim lacks indicator that 'x-ray is available for review.'
D9	Claim/service denied. Claim lacks invoice or statement certifying the actual cost of the lens, less discounts or the type of intraocular lens used.
W1	Workers Compensation State Fee Schedule Adjustment

Claim Types for Providers

Provider Type Code	Service Type	Claim Form Type
01	Hospital Inpatient and Outpatient	UB04
02	Mental Hospital – Inpatient Only	UB04
03 (group)	Behavioral Health Service Organization	CMS 1500
04	Psychiatric Residential Treatment Facility	UB04
05	PRTF2	UB04
10	ICF/MR clinic	CMS 1500
11	ICF/MR	UB04
12	Nursing Facility	UB04
13	Specialized Children's Services	CMS 1500
15	HANDS	CMS 1500
17	Brain Injury	CMS 1500
18	Private Duty Nursing	CMS 1500
20	Preventive Services	CMS 1500
21	School Bases Services	CMS 1500
22	Commission for Children w/Special Health Care Needs	CMS 1500
23	Title V – DSS	CMS 1500
24	First Steps	CMS 1500
26 (group)	Residential Crisis Stabilization Unit	CMS 1500

27	Adult Targeted Case Mgt	CMS 1500
28	Children Targeted Case Mgt	CMS 1500
29	Impact Plus	CMS 1500
30	Community Mental Health Center	CMS 1500
31	Primary Care Center	CMS 1500
32	Family Planning	CMS 1500
33	Supports for Community Living	CMS 1500
34	Home Health	UB04
35	Rural Health	CMS 1500
36	Ambulatory Surgery	CMS 1500
37	Independent Lab	CMS 1500
39	Renal Dialysis	UB04
40	EPSDT	CMS 1500
41	Model Waiver II	UB04
42	Home & Community Based Services Waiver	UB04
43	Adult Day Care	CMS 1500
44	Hospice	UB04
45	EPSDT-Related Services	CMS 1500
50	Hearing Aid Dealer	CMS 1500
52	Optician	CMS 1500
54	Pharmacy	CMS 1500
55	Emergency Transportation	CMS 1500
56	Non-emergency Transportation	CMS 1500
60/619	Dental	ADA
62	Licensed Professional Art Therapist	CMS 1500
63	Licensed Behavioral Analyst	CMS 1500
64/659	Physician	CMS 1500
66	Behavioral Health Multi Specialty Group	CMS 1500
70	Audiologist	CMS 1500
72	Nurse Midwife	CMS 1500

74	Nurse Anesthetist	CMS 1500
77	Optometrist	CMS 1500
78	Certified Nurse Practitioner	CMS 1500
79	Speech Pathologist	CMS 1500
80	Podiatry	CMS 1500
81	Licensed Professional Clinical Counselor	CMS 1500
82	Licensed Clinical Social Worker	CMS 1500
83	Licensed Marriage and Family Counselor	CMS 1500
84	Licensed Psychological Practitioner	CMS 1500
85	Chiropractor	CMS 1500
86	Other Radiological Services	CMS 1500
87	Physical Therapist	CMS 1500
88	Occupational Therapist	CMS 1500
89	Licensed Psychologist	CMS 1500
90	DME	CMS 1500
91	CORF	UB04
92	Psychiatric Distinct Part Unit	UB04
93	Rehabilitation Distinct Part Unit	UB04
95	Physician Assistant	CMS 1500